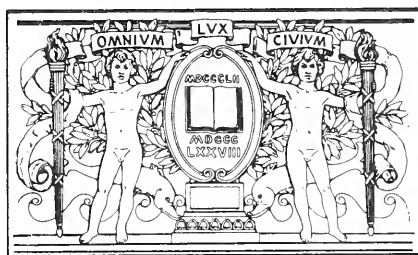


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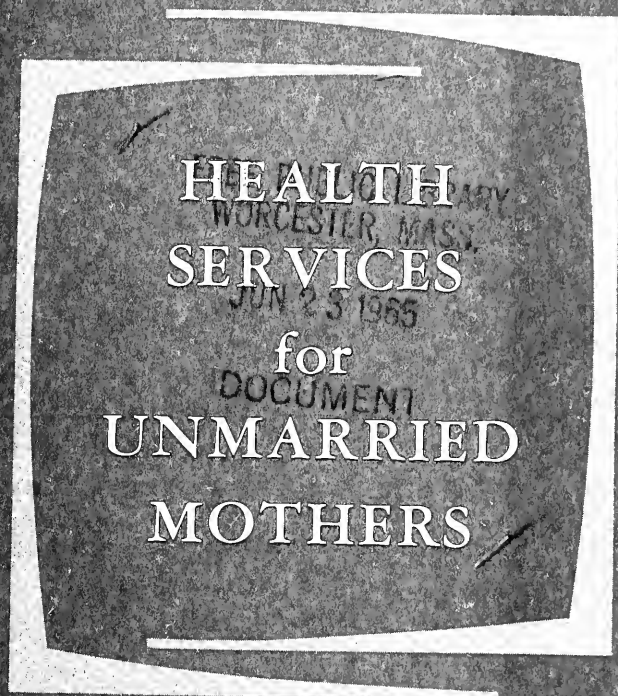
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HEALTH SERVICES  
for  
UNMARRIED  
MOTHERS  
DOCUMENT  
JUN 25 1965

## foreword

Through the years, the Children's Bureau has endeavored to assess evidence concerning the circumstances and conditions under which children are born and reared.

Certainly to be born out of wedlock is a circumstance that gravely affects the life of any child. A great proportion of these children come into the world with serious social and health hazards. These hazards relate not only to the fact of birth out of wedlock but also to the conditions that lead to it.

Some of the mothers are children themselves but, in addition, they influence the health heritage of their child. That heritage is not determined at the moment of conception, but during the years of the mother's own infancy and childhood.

The majority of unwed mothers come from low income groups and have experienced all the deprivations this implies. Accordingly, these mothers are especially in need of comprehensive health care.

Essentially, however, their need for care is the same as that of all expectant mothers. In reviewing available research and demonstrations relating to health services for unmarried mothers, the inadequacy of these services is apparent.

The Children's Bureau hopes that this review will form the base for new thinking about ways to cope with these inadequacies and that it will inspire fresh determination to deal with them.

*Katherine B. Oettinger*

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Chief, Children's Bureau  
WELFARE ADMINISTRATION

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# HEALTH SERVICES for UNMARRIED MOTHERS

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## introduction

This review of research and demonstrations relating to health services for unmarried mothers is an effort to take stock of what we do and do not know about them. It was undertaken as a step toward identifying and filling gaps in our knowledge and gaps in our activities on behalf of unmarried mothers.

A survey of this kind is likely to have a number of limitations which cannot be eluded but can and should be recognized. Five limitations should be noted in connection with the present one:

**1. Coverage.** A complete canvass was beyond our means. We were limited to the reports that were available in the Children's Bureau or could be located and obtained without undue difficulty, that met minimal requirements of systematic investigation and reporting, and that were not strictly local in significance.

**2. Time.** None of the reports included was published after 1962. Some investigations recently completed or still under way are not represented here. A number of later articles and discussions are referred to, but no direct reports of investigations published after the cut-off date.

**3. Content.** We are obviously restricted by what people have tried to find out. Not all relevant questions have been asked, quite aside from the fact that not all asked have been answered. We can merely report on a number of aspects and facets concerning which various people have tried to obtain evidence.

**4. Nature of the reports.** The methods used for investigating and reporting tend to be less than perfect—especially in the case of demonstration projects which were not set up primarily for research. A reviewer can recognize, report, and discount inadequacies of method but cannot eliminate them.

**5. Areas of competence.** The review was made by a practitioner of social research and a practitioner of social casework. We have tried

to avoid any pretense to medical knowledge we do not possess and have consulted our colleagues in the health field, but the fact remains that the review was not conducted by members of that field.

It has seemed to us that these recognized limitations were overbalanced by the following considerations:

**1. Representativeness.** Probably most of the significant points brought out by relevant studies and demonstrations are brought out in the ones covered, and probably few relevant completed studies or demonstrations that are highly significant have been omitted.

**2. Regard for evidence.** We have tried to present the evidence for and against generalizations made or challenged in the review.

**3. Critical evaluation of evidence.** We have tried to bring out conflicts as well as convergences, and weaknesses as well as strengths, in the findings reported.

Accordingly, we believe that this review does reflect the direction of evidence on the points discussed, even though specific reports or specific points may not have received their full due. It cannot be claimed that everything is included, but we believe that what is included is in accord with the available evidence. We believe, further, that by building on the evidence available we can improve our knowledge about and our services to unmarried mothers.

# HEALTH SERVICES for UNMARRIED MOTHERS

ALTHOUGH a number of studies and demonstrations cover both medical and social services, and some do not even differentiate between them in reporting, certain aspects of each call for separate discussion.

The studies that focus on or include investigation of medical services to unmarried mothers tend to give major attention to three broad concerns: 1. complications of pregnancy in births out of wedlock; 2. availability and use of medical services; 3. methods for bringing into earlier and more continuous medical care larger numbers of unmarried pregnant women.

The same study is likely to bear on more than one of these concerns, though not necessarily on all three. Efforts to bring more unmarried mothers-to-be into care usually involve both medical and social services.

## 1. Complications of Pregnancy in Births Out of Wedlock

Four statements about infant mortality rates and complications of pregnancy are so commonly made, so strongly supported by statistical reports, and so widely accepted among health authorities that at

this point it is necessary merely to summarize them :

- There is a higher death rate for infants born out of wedlock than for infants born in wedlock.
- A higher proportion of births out of wedlock than of births in wedlock are premature.
- Rates of perinatal mortality, prematurity, and other complications of pregnancy differ among ethnic groups—frequently classified as white, nonwhite, and “other” (e.g., Puerto Rican, Mexican), the rates for whites being lowest and those for nonwhites highest.
- High prematurity and infant mortality rates are associated with absence of prenatal care. Although overall rates are higher for births out of wedlock than for births in wedlock, studies have found lower rates among infants of unmarried mothers who had prenatal care than among infants of married mothers who lacked it.

### *Studies of prenatal medical care for unmarried mothers*

Among the studies reviewed, none challenged the proposition that lack of timely prenatal care is a primary factor in perinatal mortality, prematurity and other complications of pregnancy, and that adequate care would reduce such problems considerably.

Two major studies received their initial impetus from concern about the significantly higher perinatal mortality rates among children born out of wedlock in New York City (a rate that in the years studied was twice as high for the illegitimate as for the legitimate babies) and indications that apparently many unmarried expectant mothers either were not using, or were delaying use of, medical and social services. One of these studies, by New York City’s Health and Welfare Departments, focused primarily on the medical complications to which the unmarried mother and her child appeared especially vulnerable, and the adequacy of protective health and welfare services available to them.\* The other, undertaken by the Community Council of Greater New York, attempted “. . . to determine the extent to which unmarried mothers seek and obtain health and social services during pregnancy . . .” and “. . . the reasons why many women pregnant out-of-wedlock do not obtain early prenatal care and social services. . . .”\*\*

The first study was based on matched birth and infant death cer-

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\*Pakter et al., 1961.

\*\*Bernstein and Sauber, 1960, p. 10.

tificates for the years 1955-59, and data and records from the city's departments of welfare and education. The Community Council study was based primarily on hospital interviews with 520 unmarried mothers, held in the hospital within 48 hours of delivery. Both studies include comparisons with records of married women regarding the beginning and continuance of prenatal medical care, and other relevant facts.

Although these two studies deal with New York City, which in some respects is unique among metropolitan areas, their findings probably have considerable application to other urban settings. Moreover, they deal with larger samples than most studies of unmarried mothers, and were blessed with resources that made possible unusual care in study planning and execution. Thus, while—like all research studies—each has been subject to various criticisms and objections, both will be drawn on heavily in this report.

A somewhat smaller New York study, conducted at the Mount Sinai Hospital in 1956-57,\* also reported on medical aspects, but was more directly concerned with the function of the hospital social service department.

All three studies dealt primarily with women who were known through the clinics or wards of public or voluntary hospitals. None of them included patients in private medical care, as is more the rule than the exception in this kind of study. Women in private care, and married women, are referred to mainly for comparison with regard to specific aspects of care or medical condition. The omission of unmarried mothers in private care is not particularly disturbing in connection with the stated purposes of these studies, since relatively few identified unmarried mothers come into private care.\*\*

In these three, as in many studies of unmarried mothers, data were analyzed chiefly by ethnic group (white, nonwhite, and Puerto Rican), with no major breakdown by socioeconomic level. Where appropriate to the study design, married and unmarried are compared within each group. In the case of the Community Council study, the comparison between married and unmarried was made only for characteristics (such as age, color, religion) that could be compared with citywide data, since interviews were held only with unmarried mothers. The New York Health and Welfare Departments' study, based on analysis of statistical reports and agency records, included both married and unmarried subjects.

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\*Rashbaum et al., 1962.

\*\*According to data in the study by the New York City Health and Welfare Departments, about 95 percent of the unmarried mothers in that city were delivered on "ward" services, and 4.4 percent on private services. (Pakter et al., p. 694.)

A number of other studies and papers have contributed to the discussion of medical complications and medical services, and will be referred to as appropriate.

## *Marital status and complications of pregnancy*

A major focus of the study made by the New York Health and Welfare Departments was on the medical hazards of out-of-wedlock pregnancy. For all married and unmarried women, the percentage of complications was 8.0 and 10.7 percent, respectively. When the various complications are viewed separately, the differences are more striking. The maternal death rate was approximately four times as great for the unmarried (21.3/10,000 live births) as for the married (5.0/10,000 live births); the proportion of premature births among the unmarried (16.4 percent) was almost twice as high as for the married (8.5 percent); the death rate for infants born out of wedlock (48.2 per 1,000 live births) was more than twice as high as for those born in wedlock (23.9 per 1,000 live births). The rate of fetal deaths was also higher among the out-of-wedlock pregnancies.

When the rates are viewed separately by ethnic group, the picture is consistent. For each group, the incidence of all complications is greater among the unmarried than among the married. Also striking, however, is the fact that the difference between groups tends to be greater than the difference between married and unmarried within the group. Apparently the difference in overall rates between married and unmarried is affected by the fact that there are more nonwhite than white unmarried mothers, and that white married mothers—who have the lowest incidence of medical complications—constitute the majority of all mothers.

### Complications of pregnancy among:

	White	Nonwhite	Puerto Rican
Married.....	7.2%	11.3%	9.0%
Unmarried.....	8.0%	11.8%	10.0%

When the various complications of pregnancy are viewed separately, some of the differences remain more striking between groups than between married or unmarried within each group. Striking also



is the fact that for some complications (e.g., infant mortality and prematurity) the rates for in-wedlock nonwhites were higher than the rates for out-of-wedlock whites—a relation that can also be seen in the table presented above.

Another significant finding was that rates of prematurity for all ethnic groups were definitely lower among women who received shelter care, overall and within each ethnic group. And even more surprising, that for unmarried nonwhites in shelter care the rate was lower (11.5 percent) than for married nonwhites, who of course were not in shelter care (13.7 percent). The figures are as follows, for unmarried mothers who did and did not have shelter care:

Prematurity rates for un- married mothers:	White	Nonwhite	Puerto Rican
In shelter care.....	8.8%	11.5%	8.3%
Not in shelter care.....	13.6%	18.6%	14.4%

The authors comment, “this suggests that environmental factors influence the incidence of prematurity more than racial or ethnic origin,” and more than marital status (p. 854).

The figures given here are but a few selected from the report as illustrative and as pertinent to further consideration of the relations between ethnicity, marital status, amount of care and outcome of pregnancy. In connection with other complications of pregnancy also, Pakter and her co-authors emphasize the importance of “environmental factors” during pregnancy and of lifelong socioeconomic deprivation, marshaling their data to support the statement that adverse environment exerts a stronger influence on perinatal mortality and morbidity than does marital status—and, by implication, a stronger influence than does ethnic origin *per se*.<sup>\*</sup> The relations between mortality or morbidity rates and socioeconomic differences tend to be obscured by the practice of classifying on the basis of ethnic origin rather than socioeconomic status. One reason for such classification is that it is so much easier to assign ethnic identification than to establish a reliable and sensitive determination of socioeconomic status—a

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<sup>\*</sup>In line with this position, The Mount Sinai Hospital study reports that almost half of the Negro and Puerto Rican expectant mothers (48 and 49 percent, respectively) had anemia, as compared with only 17 percent of the white—without regard to marital status. (Rashbaum, 1962, p. 9.) Mussio also reports a high incidence of anemia among nonwhite unmarried mothers. (Mussio, 1962, p. 443.) In neither case was the type of anemia stated.

problem especially complex in the case of unmarried mothers.

Apparently, there is some difference of opinion among medical authorities about how much importance, if any, should be ascribed to ethnic factors aside from their association with "environmental factors." For example, some recent efforts to summarize current thinking about prematurity, as judged by birth weight, give very little importance to ethnic factors as such, while some leave open a possibility that there may be a slight genetic influence although, compared with environmental factors, it would be relatively slight.\*

The Mount Sinai Hospital study is the only one reviewed that reports on medical findings and does not show a higher incidence of medical difficulties or complications among the unmarried mothers than among the married, when patients are classified by ethnic group. On the contrary, "many of the medical problems were, as one would expect, not related to marital status, but rather to nutritional factors, lack of education and social conditions." The authors concede that their population is limited and may be biased. The 227 women pregnant out of wedlock were being cared for at a clinic that "gave priority to women who applied before their seventh month of pregnancy and thus, in effect, excluded most women who tend to be very late in seeking prenatal care."\*\*\* Nevertheless, the dissent should be noted, and is relevant to further consideration of the relations between ethnicity, marital factors, adequacy of care, and outcome of pregnancy.

## 2. Medical Services: Availability, Use and Quality

None of the studies reviewed challenged the generalization that women pregnant out of wedlock are less likely than married pregnant women to begin regular prenatal care early enough—a generalization supported by many papers and statistical reports and refuted by none that have come to our attention.† On the basis of Health Department data for 1959, the Community Council investigators esti-

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\*Thompson, 1961; Lesser, 1963.

\*\*Rashbaum et al., paper, p. 3.

†Thompson, 1961; Lesser, 1963; Yankauer, 1953.

mated that almost 40 percent of the pregnant married women in New York City began prenatal care in the first trimester, as compared with about one-fourth of the unmarried pregnant women. Seventeen percent of the unmarried mothers in the study sample received no prenatal care at all, compared with an estimated 3.7 percent of all mothers in New York City in 1959 (p. 44). According to the definition used in this study, over three-fourths (79 percent) of the unmarried mothers in the sample received an inadequate amount of prenatal care.\* Applying the definition used in some other studies (care should begin before the third trimester) almost half (47 percent) of this sample began care too late.

Pakter et al., reporting for the years 1955-59, give somewhat different figures for New York City. Despite variations in actual figures, however, the differences between married and unmarried are significant, and in the same direction, throughout all the studies reviewed.

*Characteristics associated with early and regular prenatal care*

Equally general is the finding that the amount and the timing of prenatal medical care differ substantially in different ethnic and age groups. The Community Council study reports that "the white unmarried mothers are more than proportionately represented among those who receive care in the first trimester and regularly thereafter and less than proportionately among those who do not obtain any medical care," but have a "relatively high representation among those who delay care until the seventh or eighth month" (p. 46). The findings of the Health and Welfare Departments' study also show the white unmarried mothers tending to start care late, but the difference in time period analyzed (6 months *vs.* 3) prevents comparison with regard to the first trimester. When marital status was examined within each ethnic group, in relation to the percentage who began prenatal care during the first 6 months of pregnancy, the figures were :

Prenatal care begun during first 6 months:	White	Nonwhite	Puerto Rican
Married.....	87.2%	61.7%	60.4%
Unmarried.....	36.7%	42.9%	43.5%

\*According to this study, adequate prenatal care must begin in the first trimester and include at least seven or eight visits to the doctor in the course of pregnancy.

Not only do the unmarried begin care later than the married within each ethnic group, but the white unmarried mothers tend to start later than the nonwhite or Puerto Rican, although the white married women are likely to begin earlier than the others.

The inadequate amount of prenatal care reported for the white unmarried mothers appears paradoxical in relation to the lower incidence of various complications of pregnancy found among them. We have seen that, on the whole, complications of pregnancy (including perinatal mortality) are less frequent for those in maternity homes than for those who do not have shelter care during pregnancy. The great majority of those in shelter care are white. However, the study made by the New York City Health and Welfare Departments reported very similar rates for whites and nonwhites in shelter care and very different rates for those who did and those who did not receive such care. Since many unmarried mothers in maternity homes appear to receive prenatal care only when they enter the home—late in pregnancy—it seems clear that other factors than timing of care must be involved. Among the possible other factors mentioned by various investigators are: the environment of the maternity home; the quality of the prenatal care when finally received; the quality of obstetrical care received in or through the maternity home; the general health care, including a closely supervised diet; the general health status of the unmarried mothers who are admitted to maternity homes, including their nutritional status.

These possibilities are discussed at more length later in this report, under "Correlations and Causes." It should be mentioned here, however, that a study of pregnant girls in shelter care found that even a young adolescent (aged 16 or younger) was a fairly good obstetrical risk if she was under the close medical supervision of a maternity home. No comparison was made with those not in shelter care, and the time at which they came into prenatal medical care was not specified. But the usual time of admission in a maternity home is certainly after the first trimester and more often after the second, frequently with no prenatal care prior to admission.\* The 1.5 percent neonatal death rate in this study was considerably under that reported in the one made by the New York Health and Welfare Departments.

In considering figures concerning the beginning of prenatal care, especially for residents of maternity homes, a number of inconsistencies must be recognized. On the one hand, as Pakter et al. point out, there is the possibility that "in a number of shelters early prenatal care may be given by a doctor outside the clinic, and thus may not be reported on the birth certificate by the hospital of de-

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\*Briggs et al., 1962. See also footnote on p. 9.

livery" (p. 695). On the other hand, some reports count a single visit to a physician, made solely to confirm the pregnancy, as the beginning of prenatal care—while other reports do not. In the sample interviewed for the New York Community Council study, "of the contacts with private doctors . . . 54 percent are made solely to verify the pregnancy . . ." (p. 58). Whether more consistency in reporting would strengthen or weaken the relations reported is a perplexing question—one that cannot be answered here, but must be noted. It seems unlikely that greater accuracy would eliminate them.

**Age** is also generally reported as a factor related to the timing of prenatal care. The need for bringing into early prenatal care the unmarried teenager has been receiving special emphasis in recent writing about unmarried mothers, the implication being that they are more likely than others to delay, and also that the very young ones have a special need for early care.\* The New York Community Council study found, in fact, that the unmarried mothers under 17 did tend to begin care later than those 17 or older—30 percent of them began only in the seventh or eighth month, as compared with 21 percent of the whole sample and 18 percent of those 20 to 24. On the other hand, those under 17 were less likely than others to end up with no prenatal care—about 9 percent, as compared with 17 percent of the whole sample. The study of the New York Health and Welfare Departments does not give a comparable breakdown, but does report that 89 percent of the girls who became pregnant while attending school did get prenatal care, although the timing is not specified in the published report. As the Community Council study comments, "it would seem that when the teenager's pregnancy eventually becomes known to parents or community agencies, action is taken to insure that prenatal medical care is received" (p. 45).

This study found little significant difference among other age groups, except that a relatively high proportion of those in the early twenties did not seek any prenatal care. Other studies (involving both married and unmarried women) have reported that the older unmarried mothers, especially those 40 and over, are more likely than the younger ones to get care late or not at all, and are also (quite expectably) more likely to have had other children, born in or out of wedlock.

**Education, occupation, and income.** Education is a frequently

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\*The special needs are seen as both psychological and physical. It is often stated that, regardless of marital status, girls 15 and under represent a high risk group in obstetrical care, and that those 14 and under are especially vulnerable to complications of pregnancy. See, for example, Battaglia et al., 1963.

reported factor in the timing of care. It is generally reported that the more education an unmarried mother has, the more likely she is to obtain early and regular care, and the less education she has, the more likely she is to receive care late or not at all.\* True, the residents of maternity homes, who may begin care relatively late, are likely to include more college-educated women usually from higher socioeconomic levels than do recipients of other types of service; and college-educated and professional women pregnant out of wedlock, who again tend to be better off economically, are also likely to obtain private care. It is possible, therefore, that among college and professional women education is correlated more with quality than with quantity of prenatal care. However, the great majority of unmarried mothers are not residents of maternity homes, nor are they college-educated. Accordingly, overall, the regularly reported relation between education and higher economic status and prenatal care is probably a fact, rather than an accident of the defects in sample and method so frequently found in studies of illegitimacy.

On the whole, information about occupation and income is sketchily reported in most studies and is often absent entirely. The Community Council study found that unwed mothers in sales or clerical jobs had a relatively good medical care record, while domestic servants had the poorest record and professional women the best.

Occupation and income are so closely related to education and social-cultural background that it seems reasonable to assume a relationship with prenatal care even if the evidence—although all in the expected direction—is slight. On the other hand, more satisfactory information on these points would be helpful in the difficult task of discovering which related factors are critical in determining whether or not a woman receives adequate prenatal care. It would help especially toward disclosing the relative importance of ethnic identification and socioeconomic status in this determination.

**Marital status.** Although there is unqualified agreement that insufficient prenatal care is associated with—and presumably influenced by—the cultural background, education and age of the unmarried mother, most investigators also conclude that her marital status is the overriding factor. According to the Community Council report, “. . . the differences in the timing and regularity of prenatal medical care among the unmarried mothers of various age, ethnic or religious groups, or education, are not nearly as marked as the difference between all unwed expectant mothers and married expectant mothers. One may reasonably infer, therefore, that at the

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\*See, for example, Wishik, 1959, p. 7.

present time unmarried mothers seek prenatal care much later than married women because they are unmarried" (p. 45). In line with this finding, Pakter et al. point out that the marital status factor was strong enough to reverse the familiar patterns in prenatal medical care: "Both unmarried and married nonwhites and Puerto Ricans had a better record of timely prenatal care than the unmarried whites" (I-p. 695). Apparently, also, it was strong enough to override the rather weak relation between education and amount of prenatal care, among unmarried mothers receiving medical services in clinics and wards.

Investigators are as unanimous in emphasizing the need for early and regular prenatal care as they are in the view that too few unmarried mothers and their babies are getting it. They differ when it comes to specifying how early and how much would be enough, although the differences are minor compared with the consensus about the need and about the prevailing insufficiency of prenatal care received by unmarried mothers. The definition usually specifies the time care should begin and the number of visits before delivery. There seems to be general agreement that prenatal care which starts after the sixth month is too late, and some say that it should start before the fifth month. The Community Council study stipulates at least one visit to the doctor in the first trimester and a total of seven or eight visits in the course of pregnancy. Some set the required number as low as five.\*

In all the studies reviewed, the assumption was that the visits must be to a physician, preferably an obstetrician. This assumption (discussed under "Recommendations") is not universally shared, but it was not challenged in any of the studies or demonstrations covered by this review.

### *Deterrents to early and regular prenatal care*

As has been noted, all of the studies reviewed, if they touched on the subject at all, agreed that unmarried mothers on the whole receive less prenatal care than do married mothers. At the same time, there is general agreement that many married women also fail to receive early and regular prenatal care; and that this is most likely to be true in the most deprived groups.

\* A number of studies have tried to determine the chief reasons why expectant mothers fail to obtain adequate prenatal care. Some of these, like the New York Community Council study, have concentrated on reasons why unmarried mothers do not obtain it. Some

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\*For example, Swayne et al., 1960.

have compared the deterrents affecting the married and the unmarried. And some have reported on deterrents to prenatal care in general, without differentiating between married and unmarried pregnant women. The last group includes five California studies conducted between the years 1954 and 1960.\*

On the whole, there is a good deal of agreement among studies about what keeps expectant unmarried mothers from obtaining early and regular prenatal medical care. There is agreement also that the deterrents are multiple and interacting. A woman may fail to get prenatal care for several reasons, and some deterrents (such as inconvenience) would be less effective if others (such as fear of medical examination) were not also operating.

Review of the various studies suggests that, to a large extent, the deterrents reported for married women apply also to the unmarried; but that a few reasons which hold for the unmarried do not apply, or are much less applicable, to the married. Chief among these would be the wish to conceal the pregnancy, which does exist among the married, but less frequently than among the unmarried.

There is agreement too that direct statements on this particular subject cannot always be taken at face value, especially explanations given to an interviewer, nurse or social worker by an unmarried mother. There may be doubt whether direct questions are answered frankly, or even whether a woman necessarily knows the "true" answer. This doubt was formalized in the New York Community Council study by reporting both the answers to direct questions and the interpretations of the interviewers, based on what was and was not said, and how, during the entire interview.\*\*

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\*Alameda County, 1955; California Department of Public Health Prenatal Care Study; Broker, San José, 1959; Swayne et al., 1960; California Department of Public Health Statewide Study, 1957. In addition to the separate studies, we have drawn on the thoughtful summary of Monahan and Spencer, 1962.

\*\*In this study, the interviewing was done less than 48 hours postpartum, sometimes on the ward, and with respondents who were dependent on the services of the host institution. Little was said in the report about this fact, about the physical condition of the respondents, or about possible language problems among the 19 percent who were Puerto Rican. Under the circumstances, it seems likely that answers might have been influenced by factors both physical and psychological. It seems likely, for example, that some deterrents to medical care would be overstated and some understated. An attempt to compensate for this effect was made in the study by reporting not only the unmarried mother's statement about deterrents to medical care but also the interviewer's interpretation—a frankly subjective judgment. An attempt has been made in the present report to consider the findings of this study in the light of other studies and to discuss deterrents to medical care in the light of this overall review.

It should be added that opinions differ about the reliability of information (1) obtained through interviews dealing with sensitive subject matter, (2) obtained at times of stress, and (3) obtained through different interview techniques. Some careful investigators hold that research interviews on sensitive subjects and at times of stress can be especially revealing and can help rather than harm the respondent; but that in such situations a highly structured interview (such as the one used in this study) is less rewarding than one that is more flexible. Others put faith in the highly structured interview under any circumstances. (See National Association of Social Workers, 1963.)



In relation to prenatal medical care, it seems likely that the main deterrents were identified, although the reported proportions are probably suggestive rather than precise.

For present purposes, it is significant that comparison of the respondents' statements and the interviewers' interpretations revealed differences in saliency rather than difference in substance. The same reasons appeared on both lists, but the order was modified, and both lists were reported, so that the reader is able to draw his own conclusions. The same relation holds, to a large extent, between different studies. Most of those reviewed came up with the same or similar obstacles to care, although not every item appeared on every list. The chief difference was in the relative importance attached to each reason, although—despite differences in order—there is prevailing agreement about which deterrents are major and which are minor, in the sense of deterring relatively many or relatively few expectant mothers.

For present purposes, also, the amount of agreement on items is more to the point than the difference in emphasis. The kinds of studies under review would hardly be expected to give a precise ranking of deterrents. It is conceivable, of course, that no credence should be put in direct answers concerning deterrents to prenatal care. In that case, the agreement between studies could represent merely a compounding of error. However, the extent to which actual situations seemed to correspond with the answers, the correlations between certain reported deterrents (such as indifference to obtaining prenatal care) and certain characteristics of the unmarried mothers (such as age or education), and the extent to which the reported deterrents "make sense" encourage belief that the reports come close enough to "reality" to repay careful consideration.

The deterrents to getting prenatal care soon enough, and getting enough of it, as they emerge from a review of available studies, can be grouped roughly under the following headings, of which the first three are unfailingly reported as major :

**Attitudes to prenatal medical care**

**Wish to conceal pregnancy**

**Problems concerning arrangements**

**Ineligibility**

**Medical fees**

**Attitudes to medical clinics and personnel**

**Lack of information about resources**

## Unawareness of pregnancy

### Inadequate referral

**Attitudes to prenatal care.** In one form or another, one reason for not obtaining adequate prenatal care overrides and interacts with most of the others: indifference about or resistance to getting it. A strong conviction that it was essential to the baby's well being and to her own would probably prompt an expectant mother to find ways of circumventing or thrusting aside some of the other deterrents, if she were also convinced that good care was available to her.

The prevailing assumption is that lack of effort to obtain prenatal medical care is due to ignorance or to cultural or socioeconomic patterns which take it for granted that childbearing is natural and does not require medical attention until the time of delivery. This assumption has a good deal of support in evidence. Several studies show that the more educated a woman is, the more likely she is to have early and regular prenatal care. There is ample evidence, too, that lateness or absence of prenatal care is associated with very low income. There is also evidence that income is associated with ethnic group. Moreover, there is evidence that rural and urban patterns of prenatal care differ greatly.

This attitudinal deterrent is paramount for married as well as for unmarried mothers. However, it has special force and a few special facets for unmarried mothers, not only because so many of them come from very low income groups and from homes in which pregnancy and medical care are not strongly linked, but also because of the unmarried mother's attitude toward her pregnancy.

A point seldom made explicit in connection with inadequate medical care is that, on the whole, unmarried mothers may be less eager than married ones to preserve the life of the unborn baby and may actively hope for or try to induce miscarriage. True, married mothers also have unwanted pregnancies, and some who would not resort to induced abortion would still refrain from measures that might forestall spontaneous abortion. There seems little doubt, however, that such attitudes and efforts are more frequent among unmarried mothers. Pakter et al. report, for example, that more than two-thirds of the puerperal deaths among the unmarried were the direct result of abortion, while among the married slightly less than one-third of the puerperal deaths were caused by abortion (p. 851).

Of the unmarried mothers interviewed in the New York Community Council study, 8 percent said, in response to a direct question, that they tried to induce or obtain an abortion, and 59 percent said they thought about it but did nothing to induce or obtain one. Those who avowed efforts to induce or obtain an abortion were somewhat

less likely than the others to begin regular care in the first trimester and more likely to delay care until the seventh or eighth month\* (p. 97-98).

**Concealment.** Among the major deterrents for unmarried mothers is one relatively infrequent among married mothers-to-be—namely, a desire to conceal the pregnancy. This, apparently, accounts for the lateness with which so many residents of maternity homes begin prenatal care. They may go to the doctor once, just to confirm the pregnancy, and then have no further medical supervision until they enter the home, which is likely to be in the third trimester.

The age of the unmarried mother has a good deal to do with the intensity of her wish for concealment. According to the interpretation of the interviewers in the Community Council study, 70 percent of the girls under 17 delayed care for this reason, but only about 18 percent of the entire sample. (According to the statements of those interviewed, a wish to conceal the pregnancy characterized only 9 percent of the sample.) The school girls were usually concerned about being excluded from school, and often tried to conceal the pregnancy from their parents also. In some cases, however, the girl's mother helped to keep the school from knowing about the pregnancy and participated in delaying medical care.

It is generally taken for granted that efforts to conceal an out-of-wedlock pregnancy (and the success of such efforts) are strongly associated with socioeconomic status. This assumption is supported by the evidence, and is recognized in the reports of the National Vital Statistics Division:

**"There is no direct knowledge as to the characteristics of the unwed mothers who may be misreporting legitimacy status. It seems likely, however, that the decision to conceal the illegitimacy of the birth is conditioned by attitudes in the mother's social group toward her and toward children born out of wedlock. Also, the ability (economic or otherwise) to leave a community before the birth of the child is an important consideration. These factors are generally believed to operate in the direction of a proportionately greater understatement of illegitimacy in the white race than in the nonwhite and in the older age group of women as compared with the younger." (NOVS, 1958, Sec. 12, p. IV.)**

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\*Nevertheless, it should be noted that none of them named the desire for abortion as a main deterrent to prenatal care and that, according to the evaluation of the interviewers, it was a main deterrent for only 3 percent (p. 97).

What is less generally recognized is that a wish to conceal may exist, even though it is less compelling than other, possibly conflicting, wishes; and also that inability to conceal the pregnancy may give a deceptive impression that there is no wish to conceal it.

In most studies and demonstrations, the wish of an unmarried expectant mother to conceal her pregnancy is treated as a unitary factor, more likely to be found in some groups than in others. Yet there is ample evidence that, on the one hand, the impulse to conceal an out-of-wedlock pregnancy is found in all groups and, on the other, that in any group it functions selectively. Even among girls who presumably would stand to lose most if their condition were known, there may be segments of their associates with whom secrecy must be carefully maintained and others in which the fact can be openly admitted. For example, a middle-class, white, Protestant high school or college student may have little or no concern about her classmates knowing she is pregnant and may even take for granted that they have come to their own conclusions about her condition. However, it may be very important to her, because of shame, her official standing at school, or other reasons, that the authorities not know, or at least that there be no open acknowledgment of her condition. Concealment is an attainable goal for her through shelter residence, since her baby is likely to be surrendered in adoption, and so concealment becomes a prime element in her planning.

A Negro girl of low socioeconomic status, for whom her mother is receiving an Aid to Families with Dependent Children grant, or the mother of such a girl, also feels the need for concealment—this time not only from the school but also from the public assistance worker who, she fears, will find her ineligible for continued assistance if she learns about the pregnancy. However, an unmarried mother on public assistance is unable to pay for shelter care secretly, and comes to realize that the worker is bound to learn of her pregnancy sooner or later, since there is little likelihood of a Negro baby being adopted. One way or another her detection is ultimately inevitable, so she remains in the community and faces the music. It often looks as though concealment is not a problem for her, although it is well known that many relief recipients do attempt to conceal a pregnancy from the public assistance worker as long as possible.

In any ethnic or socioeconomic group, there may be an effort to conceal a pregnancy from any or all of the following: own parents, putative father, school officials or other authority figures, the putative father's family, one's peers, one's siblings, one's father's business associates, one's mother's social circle, one's own children, one's self—and probably others could be added. Some element of concealment or some kind of dissembling is probably present at some time in all but a very few cases of out-of-wedlock pregnancy, although the duration

and the intensity of the effort to conceal may vary widely.

The importance of this deterrent is clear, and is clearly recognized by investigators. The New York Community Council study reports that "although, according to the interviewers' evaluation, the desire to conceal is one of the main deterrents for 18 percent of the unmarried mothers, as many as 28 percent say that they are much concerned about their condition being known and another 25 percent indicate they are somewhat concerned. Less than half of the women are completely unconcerned about their families' and friends' knowledge of the pregnancy. Furthermore, both groups—those very concerned or only somewhat concerned about concealing the pregnancy—defer prenatal care to a much later period than do the women who feel no need to conceal . . . . Only 43 percent of the women who say they want to conceal the pregnancy, to a greater or lesser degree, obtain prenatal care in the first or second trimester and regularly thereafter, compared to 62 percent of the unmarried mothers unconcerned about concealment . . . the unwed mothers who say they are very much concerned to conceal the pregnancy include relatively more whites and those who are not at all concerned, relatively more Negroes and Puerto Ricans. In each ethnic group, however, a significant number are either very much or somewhat concerned to conceal the pregnancy" (p. 97).

A different kind of concealment is occasionally involved, namely the unmarried mother's wish to conceal her pregnancy from herself. Some, especially those under 20, refuse or are unable to face up to the fact that they are really pregnant, and so postpone as long as possible the moment of admitting it, even to themselves.

**Problems concerning arrangements.** The difficulties, adjustments, and arrangements often required in order to obtain medical care are emphasized in most discussions of deterrents, and tend to come high on the list. This cluster of difficulties includes problems of transportation, inability to get to the clinic during the specified hours, the need to make arrangements for the care of children during the mother's absence (if there are other children), concern about the length of time one must wait there, the problems—financial and social—of taking time away from work, especially when one is trying to conceal her pregnancy as long as possible.

This kind of reason for failure to obtain care is sometimes referred to as a "rationalization". Whatever truth there may be in the description, such reasons furnish examples of interaction among deterrents, so that one is compounded by another. It may seem deadly real to the expectant mother who says this is why she did not get to the clinic until she was 6 months pregnant. At the same time, if she were convinced that getting medical care was of paramount importance, or were convinced she would get care that was good for her,

or found the experience sustaining and encouraging, she might be more determined or more ingenious or more ready to exhaust herself in devising ways of overcoming the difficulties in arrangements.\*

**Ineligibility.** Expectant mothers who apply for free medical care may be refused because of requirements relating to time, place, money, or parental consent. Some clinics will not accept a pregnant woman for prenatal care if she applies after the second trimester.\*\* Expectant mothers may be turned away because they have not lived in the locality long enough to be eligible for clinic services; or because they have come to the wrong clinic for their section of a big city. Some unmarried mothers-to-be, especially the very young ones, are easily discouraged in their efforts to obtain medical care, and refusal by a facility in the wrong district may mark the end of those efforts—especially if there is no definite referral and follow-through to see that they get to the right place. Minors may also be put off by the requirement that they get their parents' consent to be served by a clinic.

When residence requirements make a woman ineligible for free care, she may lack the money to pay a medical fee. A study conducted in Alameda County, California, tried to discover what happened to 123 expectant mothers (married and unmarried) who were ineligible for county hospital clinic care because of lack of residence or too much income. Monahan and Spencer, reporting on this study, say that "Of the 123 patients, more than half (66) had received either inadequate or no prenatal care . . . . Of 106 patients who ultimately obtained some prenatal supervision, either through private or semi-private sources or eventually at the county hospital clinic, half were delivered as emergencies at the county hospital . . . . Knowing that under the law the county hospital has to accept them if they come to delivery as emergencies, many of the women make no other arrangements for care" (p. 115).

Regardless of marital status, it is reported in numerous studies, and is a familiar observation, that women who are ineligible for free care and do not have enough money to pay for private care solve the problem by waiting for emergency care at the time of delivery. All five of the California studies summarized by Monahan and Spencer found that ineligibility for free care and insufficient funds for private care were factors making for little prenatal care, or none at all. For the most part these studies did not differentiate between married and unmarried mothers, although one of them reported that

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\*Bernstein, 1962, p. 58.

\*\*Lesser, 1963; Rashbaum, 1962.

the absence of a husband was associated with less adequate prenatal care. The New York Community Council study of unmarried mothers also reported that ineligibility was a factor, affecting 6 percent of the sample, according to the interpretation of the interviewers.

Specific eligibility requirements differ considerably from one community to another. The failure to receive prenatal care because of eligibility requirements is a constant, however, although some studies give it more prominence than others do. Another constant is the return for emergency service of women who earlier had been turned away as ineligible for prenatal care but who, according to law, must be accepted if they apply when they are in labor.\*

It should be noted that, although the problem of ineligibility is a constant in studies of deterrents to adequate prenatal care, it is seldom if ever listed as a deterrent for a large proportion of unmarried mothers. This may be because, regardless of eligibility, other factors take precedence in precluding adequate care. At the same time, because of interaction between deterrents, eligibility might bring more mothers into care than ineligibility keeps out of care. That is, if the problem of eligibility were eliminated, some of the other deterrents might be less effective.

**Medical fees.** For the unmarried mother who is not eligible for free care, or chooses not to apply for it, the cost of adequate prenatal care may be prohibitive. Some may save the little money they have, dispensing with prenatal care, in order to be delivered privately. Some who have an income above the level for eligibility nevertheless do not have enough to pay for private care. A small study, including both married and unmarried mothers, reports:

"Of the 20 women who delivered at the county hospital, only 5 received notices that they did not have to pay their bills immediately. Three have had their bills turned over to private collection agencies and the rest were trying to work out some plan for monthly payments. This will probably be a factor in deterring them from receiving early care for future pregnancies. Consequently, when considering the problem of prenatal care, one must remember that free prenatal care appears to be nonexistent in this county." (Broker, 1959, p. 13.)

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\*This solution probably accounts for the fact that, despite widespread inadequacy of prenatal care, 97 percent of all births in the country were hospital births, according to NVSD, 1961, p. 1-13.

It is often claimed that a major reason why unmarried mothers turn to the "black market" or the "gray market" is their need to have someone pay the costs of medical care. This claim has not been conclusively supported or refuted, so far. However, there seems little doubt that some unmarried mothers do dispense with prenatal care solely because of the expense. Some of these would be ineligible for free care because of residence requirements—especially those who had left their own homes in order to conceal the pregnancy. Others, apparently, would rather have no prenatal care if they cannot have private services. Again, this proportion is consistently reported as relatively minor in comparison with the proportion responding to some other deterrent. The interviewers in the New York Community Council study estimated that 7 percent of the sample were deterred from seeking prenatal care because of its expense, although only 4 percent of the sample named it as a main deterrent. This study included no patients who were delivered on private services, but estimated that they would represent a very small percentage of all unmarried mothers—an assumption that seems to have ample support from other sources.

The studies and demonstrations reviewed in this report are concerned with services to unmarried mothers. They do not cover the "invisible" unmarried mothers who are not identified as such. That an "invisible population" exists is known, and although its precise size has not been determined there is reason to believe that, as noted above, it represents a small proportion of unmarried mothers although a far from negligible number of individuals.

There is no firm evidence about the relative proportion of the "invisible population" that turned to private care, or to independent adoption sources, *because* of the cost of medical care. The few studies found that bore directly on this question were for the most part small and unsystematic, and more concerned with adoption practices than with reasons why the unmarried mothers turned to private sources rather than to voluntary or public agencies for their prenatal medical care. There is some question whether the cost of medical care is as determining a factor as has often been assumed, in an unmarried mother's decision to turn to nonagency sources. Vincent concluded that financial considerations are not the primary influence in the unwed mother's decision.\* His discussion, however, is focused less on medical than on social services, and less on the need for meeting expenses than on the possibility of financial gain. None of the studies reviewed has disagreed with Vincent's finding that desire for pecuniary gain is not a major motive determining the course of most unmarried mothers,

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\*Vincent, 1961, p. 209.



although the desire for private medical care and the cost of such care are often believed to influence a certain number.

**Attitudes to medical clinics and personnel.** A cluster of deterrents could be grouped under the head of fear or anxiety. Some pregnant women, married or unmarried, dread a medical examination, are afraid of doctors, are uncertain what the examination will involve or what is expected of them. This kind of dread is reported by the California studies of both married and unmarried mothers, but may be stronger among the unmarried. The interviewers for the New York Community Council study thought it an important deterrent for about 1 in 11 (9 percent) of the unmarried mothers to whom they talked. Like so many of the deterrents, this one may be more potent in interaction than by itself. If a woman sees no urgent need for prenatal care and in addition shrinks from the ordeal of a medical examination, the aversion does not need to be violent in order to tip the balance. A half-hearted conviction of need for prenatal care may be further attenuated by the lack of privacy or time that would make it possible to talk with the doctor, and lack of continuity in medical personnel, so that instead of developing a relationship that could counteract dread of doctors and medical examinations a new problem must be met each time. These anxieties are not calculated to offset the fatigue attendant on a long trip to the clinic and a wait of several hours—perhaps followed by hearing that she cannot see the doctor today and must return tomorrow.

Linked to fear of the medical aspects, and similarly interactive with other deterrents, is dislike of what might be called the social aspects of the clinic experience. Some studies mention the forbidding setting, brusqueness of clinic personnel, apparent lack of concern for the patient's needs—such as keeping her waiting for hours in order to be seen for a few minutes. This element comes out strongly in some New York studies of unmarried mothers (Community Council, Rashbaum) and also in the California studies that included both married and unmarried mothers. Some of the women questioned in the San José study reported that “they don’t talk nice to you.” Another study links the forbidding atmosphere of the clinic with reports that a number of women who had received prenatal care for a previous pregnancy were not seeking it in the current one.

Anxiety or dislike is usually described as representing a minor rather than a major deterrent. The New York Community Council study found that “with respect to about three-quarters of the clinic contacts, no spontaneous criticism is offered by the unwed mothers and, indeed, half the contacts call forth spontaneous praise. . . . Even in response to direct questions about clinic hours, personnel, etc., less than half the contacts are commented upon unfavorably. Still it

is not without significance that [in] . . . 17 percent of clinic contacts the women feel they have to wait too long for service, and that 10 percent of contacts result in unfavorable comment about the physical facilities and for 8 and 6 percent, respectively, that the hours are not convenient or the personnel are too hurried in their treatment.”\*

A related problem, occasionally mentioned, is difficulty of communicating with clinic personnel for an individual who does not know English or can speak it only a little and with difficulty. This difficulty probably affects relatively few, except in certain localities, but it is definitely present in New York City and in California. A report on a different but related subject points out an especial need to focus greater attention on non-English-speaking patients “because, not only do many not understand instructions, but they do not realize they have misunderstood.”\*\* The Mount Sinai study points out, not only that the language barrier has been an obstacle in reaching Puerto Rican patients, but also that *they* are expected to take initiative in providing interpreter service.†

It is universally recognized that, to a large extent, these social-context problems in maternity clinics are the direct results of overcrowding and understaffing. The fact remains that delay for the patients and pressure for the staff often combine to produce an atmosphere which repels rather than invites. It is an atmosphere hardly conducive to overcoming a combination of resistance, anxiety, and indifference about getting prenatal care.

**Lack of information about resources.** Findings differ concerning ignorance about the availability of medical care. The New York Community Council study reports that the availability of medical care was well known to its subjects and lack of information did not in itself constitute any real deterrent. Some of the California studies, on the other hand, reported that a substantial minority of the married and unmarried mothers in their sample did not know they could obtain services from a clinic. Presumably, then, some kind of ignorance about available resources probably does constitute a deterrent to some unmarried mothers. At the same time, on the whole, this appears to represent a minor rather than a major obstacle to adequate prenatal care for unmarried mothers.

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\*Time pressure on clinic physicians may be responsible for the fact that one study reports greater ability on the part of the patients to communicate with nurses or social workers than with medical doctors. A study in a different area reported that social workers and interns achieved better results in a psychiatric clinic than did senior psychiatrists, apparently because they were under less pressure and could give more time and more concerned attention than could the rushed senior staff members. (New York City Committee on Mental Hygiene, 1949.)

\*\*Institute of Welfare Research, *Annual Report* 1962-63, p. 43.

† Rashbaum et al., 1963.

**Unawareness of pregnancy.** A deterrent reported as minor, but nevertheless surprisingly frequent, is that the unmarried mother did not know she was pregnant (a situation different from knowing but refusing to admit it, even to oneself). According to both the reports of the respondents and the interpretation of the interviewers in the New York Community Council study, 8 or 9 percent of their sample failed to obtain adequate prenatal care because they did not know they were pregnant. In some instances this could result from chronic irregularity of menses. However, reports of ignorance about how babies come and how a woman knows she is pregnant are found in some studies of unmarried mothers and also in studies of other women in low income groups.\* There seems no doubt that such ignorance exists among a small minority of unmarried mothers. Whether it represents lack of access to information or repression of information is a question that seems not to have been explored in the studies reviewed for this report, and one that—however interesting—would not command the highest priority among questions still to be answered.

**Inadequate referral.** A deterrent reported often by practitioners and research investigators, but almost never by the unmarried mothers, is failure of an agency or individual to make, or to follow through, a referral. The New York Community Council study reports that, of the unmarried mothers in their sample who went to a private doctor, over half (54 percent) went solely to confirm the pregnancy, and that even when the original intention was to obtain medical care, "almost all contacts with the private doctor are discontinued either because the unmarried mother cannot afford the fees, moves to another place, or for other reasons" (p. 58). Three-fourths of the clinic contacts (76 percent), on the other hand, were initiated in order to obtain continued care, and only 4 percent to confirm the pregnancy.

There are frequent reports that many doctors do not make a specific referral to a source of prenatal care and that those who do seldom make any move to insure that it is followed through. In the New York Community Council study, private doctors were the first medical contact for 42 percent of the sample but the sole medical contact for only 6 percent of them. "The private doctors do not make any referral in about two-thirds of the cases and in the remaining instances, where they do refer the expectant unmarried mother to either a clinic, social agency or elsewhere, more than half the time they do not make any arrangements for the woman but simply leave it up to her to follow through on the referral" (p. 100). Only 5 percent of the clinic contacts resulted from referrals by private doctors.

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\*For example, Hylan Lewis, 1961.

Equally striking are the findings in this study about lack of effective referral from schools, courts, and public welfare agencies. The unmarried mothers who are receiving public assistance are much less likely than others to obtain care in the first trimester and regularly thereafter, and somewhat more likely to receive no prenatal care at all. The receipt of public assistance is not necessarily the reason for the difference, since on the whole the unwed mothers on assistance tend to be older women, often with previous children, who generally delay care longer than younger, childless women. Nevertheless, it might be expected that the contact with social investigators would have resulted in effective referral for this group.

### *Quality of prenatal medical care*

In the list reported above, clinic attitudes and atmosphere have been cited as deterrents to seeking medical services, although not as major deterrents. On the other hand, the quality of the strictly medical care received by unmarried mothers was seldom discussed, either as a deterrent or as an appropriate subject for investigation. Studies and demonstrations often appear to assume that any medical service is good medical service, and that if the unmarried mother sees a physician all is well. Outstanding exceptions to this rule are found in the New York Health and Welfare Departments' study of unmarried mothers and one or two of the California studies that investigated maternity care without reference to marital status. Aside from these, prenatal care was referred to in strictly quantitative terms: how early it began, or sometimes, how many visits were made, but not what procedures were included, how well they were performed, how the content of care varied from one group to another.

In California, a statewide study of prenatal care received by obstetrical patients (married or unmarried) in county hospitals was prompted by such facts as the following: one newborn in every eight in California was delivered in a county hospital; county hospitals were showing prematurity rates 50 percent higher than the rates in private hospitals, neonatal death rates 60 percent higher, and maternal death rates 200 percent higher. The added dollar costs to the counties for hospital care of premature infants were estimated at \$1.3 million a year.\*

Data were collected through personal visits by a physician and a social worker from the State Health Department to every local health department, county hospital, and local welfare department

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\*Statewide study, 1957.

having a medical care program. Information was obtained from 93 prenatal clinics.

The criteria used for assessing quality of prenatal care included: the number and kind of professional staff present in the prenatal clinics; the amount of time allowed for physicians and nurses to discuss patients together; the clinic procedures used; the amount of time clinic physicians spent with the patients; and the degree of restrictiveness in eligibility policies.

The survey revealed that physicians in specialized prenatal clinics spent from 3 to 45 minutes per patient visit, and that the scheduled nurse time ranged from 2 to 41 minutes per patient. In many clinics the physicians were predominantly interns and residents with little supervision. Obstetricians and general practitioners were often not paid for their services. Only a minority of the clinics included regular participation by public health nurses or by nutritionists or dieticians (p. 2).

It was found also that the commonly accepted procedures in prenatal care were not uniformly performed on all mothers, nor were the commonly accepted instructions given to all mothers. Written nursing manuals on clinic policies and procedures were available in only 15 hospitals and 7 health departments. Moreover, 40 percent of the agencies responsible for determining eligibility of mothers for prenatal care prior to labor did not have in writing the policies relating to such eligibility, so that their application varied from time to time and from place to place.

The purpose of the study was descriptive. It does, in the words of the report, "document the deficit in prenatal care received by mothers from low income families and indicate that much public prenatal care falls short of criteria for good care. . . ." It does not claim to reveal whether the difference in prematurity and mortality rates stemmed from differences in the quality of medical services obtained in public and private hospitals, from differences in the amount of prenatal care received by the expectant mothers (married or unmarried) before delivery, or from other causes. It seems likely that more than one cause would be involved. And it is relevant to our present inquiry since the great majority of unmarried mothers are delivered in public hospitals. The few analogous studies available suggest that California probably differs from other States more in the energy devoted to investigating and improving these services than in the quality of the services to be improved.\*

The study conducted by the New York City Health and Welfare Departments, which did give information specifically about un-

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\*Yankauer, 1953; see also discussion by Lesser, 1963; Thompson, 1961.

married mothers, reported on differences in clinic procedures employed in different types of hospital services. Some differences were evident in the kinds of medical maternity care received by married and unmarried mothers—although, as so often happens, analysis suggests that marital status is not the chief factor determining differences. The category of hospital (voluntary, proprietary, or municipal) and the kind of service (private or “ward”) utilized by maternity patients appear to be correlated with ethnic group and with marital status. However, among nonwhite and Puerto Rican mothers marital status had a relatively slight effect upon the type of service used, since (chiefly for economic reasons) the majority were delivered on the ward services of the municipal and voluntary hospitals. According to this report the majority (85.8 percent) of births to married white women occurred on the private services of hospitals, and only 12.2 percent on ward services.\* Among the unmarried whites, the majority (81 percent) occurred on ward service and only 17.3 percent received private care (see table below). Among nonwhites and Puerto Ricans the great majority, married or unmarried, were delivered on the ward services of the municipal and voluntary hospitals, this majority being in each case higher for the unmarried than for the married mothers. The authors comment: “The fact that a somewhat higher proportion of unmarried white mothers received private care (17.3 percent) than did the married nonwhites (14.6 percent) reflects the lower socioeconomic level of the nonwhite group generally.”\*\*

**Percent receiving ward service:**

	White	Nonwhite	Puerto Rican
<b>Married</b> .....	12.2	82.1	90.4
<b>Unmarried</b> .....	81.0	97.4	97.5

Although these differences in type of care have socioeconomic causes, apparently they have medical effects, for data on mode of delivery by marital status and by ethnic group showed differences at-

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\*Factors contributing to the proportion of white married mothers who receive private care are the presence in this group of most of the city's economically better off mothers, and also the great extent to which the more prosperous working class families have health insurance covering maternity care as an employment benefit.

\*\*Pakter et al., I, p. 693. In New York City during the period studied, only 0.2 percent of the married and 0.4 percent of the unmarried were delivered at home.

tributable chiefly to the type of hospital service utilized. Spontaneous deliveries are much more frequent on ward services than on private services, while "deliveries with outlet forceps are more common on private services." The proportion of cesarean sections, somewhat higher on private than on ward services, was twice as great for the married whites as for the unmarried whites, while for the nonwhites the reverse was true. After analyzing the figures, the authors comment that "the differences in the rates in large measure may have reflected differences in standards of obstetric practice rather than variations in indications for cesarean sections" (pp. 692-696).

The relation between type of service and medical procedures is significant for married as well as for unmarried women. On the basis of their analysis, Pakter et al. conclude that "with the exception of the married whites, all expectant mothers depend primarily upon the public services for their maternity care" (p. 693). Thus, clinic and ward services are responsible for ushering into the world a substantial proportion of the babies born in this country, regardless of their birth status.

The exact size of this proportion is difficult to estimate. According to the report of the President's Panel on Mental Retardation, 35 percent of the babies born in cities with over 100,000 population are born to "medically indigent" mothers—that is, mothers who must be given free service if they are to receive any at all.\* The report adds that in New York City in 1960, 40 percent of all maternity deliveries were general service deliveries (not private patients) and, in 1959, 60 percent of the deliveries in the District of Columbia were general service deliveries. A national estimate of the proportion receiving general service is not available. However, regardless of the elusive national figure for all mothers, there is no doubt that the great majority of babies born out of wedlock are delivered on general rather than on private services.

Whether improvement of the medical care available to patients who receive free services would result in greater use of those services for prenatal care has not been determined. That free services, on the whole, are below optimum standards seems to be established and is widely recognized by physicians concerned with maternal and child health.\*\*

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\*President's Panel on Mental Retardation Report, 1962, p. 52.

\*\*\*"On the Obstetrical Services of these large charity hospitals, the massiveness of the prenatal clinics is unbelievable. It is simply not possible to give adequate prenatal care under these circumstances of too many patients; too few doctors, nurses, social workers, etc.; and inadequate facilities. Each patient is seen for only a very few minutes by a doctor. The doctor does not get to know the patient and the patient does not get to know the doctor. Many important aspects of pre-natal care have to be omitted. In a recent study in our hos-

It is also generally agreed that, to a large extent, the inadequacies in medical and psychological aspects of prenatal care, as offered in clinics, result from understaffing and overcrowding. If it were possible to induce all expectant mothers to seek prenatal care, problems of overcrowding and understaffing would be increased tremendously.

Clearly, then, what is required is far more than to convince pregnant women of the need for prenatal care. It is necessary, in addition, to increase radically the resources for offering prenatal care and also to improve both its medical and social aspects. None of these points is news to the harrassed physicians and nurses who struggle to bring good medical services to those who need them. Perhaps, however, the public is insufficiently aware of all the problems surrounding the need for prenatal care, and of the social, medical and financial costs of failure to meet the need.

These problems affect all women who need financial help in meeting the medical needs of pregnancy. This description, however, applies to the great majority of the unmarried mothers in this country. That the need extends beyond the unmarried mothers does not diminish the impact of these problems on them, the urgent importance of alleviating the problems, or the costs of failing to do so.

### *Correlations and causes*

A number of familiar relationships are supported by this review: that, on the whole, complications of pregnancy (including prematurity and infant and maternal mortality) are more frequent among unmarried than married mothers; that, on the whole, unmarried mothers are less likely than married mothers to obtain early and regular prenatal care; that such characteristics as age, education, occupation, and ethnic background are associated with amount of prenatal care and also with the frequency of complications of pregnancy. A number of the studies suggest, however, that marital status in itself may be less important than other factors in determining the course and outcome of pregnancy, although it appears to be a strong influence in determining the amount of prenatal care.

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pital, it was found that 23% of all patients delivered came to the hospital first when they were in labor, having had no prenatal care. Only 11% of all delivered patients came for prenatal care in the first trimester of their pregnancy. This is in marked contrast to the experience in private practice. 90-95% of the patients delivered by private obstetricians have had prenatal care beginning in the first trimester. I point to our hospital only as an example of a situation I know to exist in almost all of the large charity hospitals in this country" (Thompson, 1961, pp. 9-10).



Considerable consensus has been found about the reasons why unmarried mothers fail to obtain early and regular prenatal care. The three major deterrents were generally agreed to be: indifference about obtaining prenatal medical care, the unmarried mother's wish to conceal the pregnancy, and difficulties in making the arrangements necessary to get to a clinic and to wait there long enough for an appointment. Some other deterrents were reported frequently, although they were found to influence a smaller proportion of unmarried mothers: ineligibility for free medical services, the cost of private medical care, anxiety about or dislike of medical clinics and personnel, lack of information about available resources, unawareness of the unmarried mother that she was pregnant, inadequate referral to sources of medical care.

It was generally agreed that most unmarried mothers who failed to obtain early and regular care did so for more than one reason; that the reasons were interactive, so that the presence of one deterrent (such as fear of a medical examination) might strengthen another reason (such as difficult transportation or lack of someone to take care of other children); and that the significance of a particular deterrent was influenced by age, by social, economic, or cultural status, and by education.

The evidence seems unambiguous that unmarried mothers are likely to receive less prenatal care than married ones. The evidence seems unambiguous also that low socioeconomic status is related to complications of pregnancy, and to obtaining less prenatal care than is considered optimum. There is reason to believe that socioeconomic status may also be related to quality of medical care during pregnancy and delivery.

Two relationships are more ambiguous. There is a question whether ethnic background in itself, aside from its social and economic concomitants, has an appreciable influence on the course and outcome of pregnancy. The possibility of some genetic components has not been conclusively ruled out; neither has it been conclusively ruled in. This is a medical question which needs to be answered. However, the answer is not prerequisite to improving the quality, availability and use of medical services.

The other ambiguous relationship is between early, regular prenatal care and complications of pregnancy. No investigator or commentator included in this review has questioned the existence of a strong association between complications of pregnancy and late, insufficient prenatal care. Several, including Pakter et al., have documented the existence of this association. The Mount Sinai study reports that, when amount of prenatal care is held relatively constant, scant differences are found between married and unmarried mothers with regard to complications of pregnancy—suggesting that amount

of prenatal care is a potent influence (although others may also be potent).\*

At the same time, the Pakter study shows that, overall, white unmarried mothers, who tend to wait longest for prenatal care, have fewer complications of pregnancy than do nonwhite or Puerto Rican married mothers; and that for mothers in maternity shelters, complications of pregnancy averaged about the same in all three groups, and were lower than the rates for those who did not have prenatal care. Nevertheless, it is proverbial that, as is reported in several of the studies reviewed, many unmarried mothers in maternity homes begin prenatal care relatively late.

The repeated evidence that complications are higher among those who lack prenatal care than among those who receive it is too strong to challenge. However, the strength of the association does not necessarily prove that absence of prenatal care is the sole cause of the higher incidence of complications among those who fail to receive it, or even that it is the primary cause of higher incidence.

For all married and unmarried women, regardless of ethnic background, the percentage of complications reported by the New York Health and Welfare Departments' study, was 8 and 10.7 percent, respectively. Yet, although unmarried white women had a poorer record of prenatal care than nonwhite and Puerto Rican, complications of pregnancy were higher for the two latter groups, with the differences between groups somewhat larger than the differences between married and unmarried within each group. This suggests that, although marital status may be a factor in promoting or deterring from prenatal care, prenatal care by itself does not wholly explain the incidence of complications.

This same study and the Mount Sinai study, as well as some others, suggest that the health status and health practices of a pregnant woman may be equally potent factors in determining the course and outcome of the pregnancy. Reviews of studies not primarily concerned with unmarried mothers present strong evidence that complications of pregnancy are more frequent among the poor than among the prosperous.\*\*

The relatively low incidence of perinatal accidents among unmarried mothers in shelter care invites speculation about the relative importance of early and regular prenatal care and of life conditions among those unmarried mothers who tend to come into early care or

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\*In many studies and statistical reports, not specifically concerned with unmarried mothers, there is evidence that prematurity rates run two to three times as high among mothers who have received little or no prenatal care as among those who have had early and regular care. See, for example, Lesser, 1963; Stitt et al., 1964; Thompson, 1961.

\*\*See, for example, Shapiro, 1960; Lesser, 1963; Thompson, 1961.

to use shelter care. Since the mothers who use shelter care are likely, on the whole, to come from more advantaged groups economically, than most mothers who have little or no prenatal care, it seems likely that their more favorable general health and physical development which depend more on level of nutrition over a lifetime than on immediate care during pregnancy, may give them an additional advantage over unmarried mothers in the more deprived groups, who are less likely to have shelter care. It is probable, as the New York Health and Welfare study report suggests, that the immediate environment during pregnancy and the accessibility of obstetrical care are factors in the more favorable results for unmarried mothers in maternity homes. But the influence of early environment and health status, including nutrition throughout childhood, cannot be ruled out as an additional factor. If this be true, efforts to reduce perinatal and maternal casualties would have to reach back into the childhood of the prospective mother and start with the problems of poverty and ignorance as they affect her from her earliest years.

In considering the influence of environmental factors before pregnancy and during pregnancy, as compared with the adequacy of prenatal care, conclusions are made more difficult by the nature of the available data. The figures we get are usually presented for married as compared with unmarried women, and for white women (married or unmarried) as compared with nonwhite (and sometimes with "other"). The difficulty of determining the relative influence of factors involved in the differences revealed by such comparisons is increased by several facts about the population of the United States and the population of unmarried mothers.

In this country, nine-tenths of the population are white, and the great majority of white women of child-bearing age are married. Three-fifths of the births out of wedlock are to nonwhites. Accordingly, if we compare all married mothers with all unmarried mothers we are, in effect, comparing white with nonwhite, since at least nine-tenths of the married are white, and a majority of the births out of wedlock are to nonwhites.

Moreover, although an appalling number of white people are poor, the impoverished represent a minority of the white population. On the other hand, although some of the nonwhite population are prosperous, the majority are poor. Therefore, when we compare white with nonwhite we are, in effect, comparing the prosperous with the impoverished. When we compare all married mothers with "all" unmarried mothers\* (i.e., all identified unmarried mothers) we are still,

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\*It would be more accurate, although more cumbersome, to speak usually of annual births out of wedlock rather than of unmarried mothers, since parity is higher among the nonwhite than among the white and higher among the poor than among the prosperous.

in effect, comparing the prosperous with the impoverished, since the majority of children born out of wedlock are nonwhite. Moreover, the identified and studied unmarried mothers—white or nonwhite—tend to be the ones who cannot afford private care, and the “invisible” unmarried mothers who do not come into clinic or agency services are invisible chiefly because they have the means and the sophistication to remain unidentified.

It has also been shown that (with the possible exception of white unmarried mothers) the prosperous are more likely than the poor to obtain early and regular prenatal care. And there is ample evidence that the great majority of identified unmarried mothers are from low income levels.\*

It follows from these relationships that, in effect, we are comparing the prosperous with the poor in all three of the following comparisons: white with nonwhite; married mothers with unmarried mothers; all mothers who do with all mothers who do not obtain early and regular prenatal care. (The identified prosperous white unmarried mothers are so small a proportion of this last comparison that they do not substantially affect the generalization.)

If, on the whole, those who receive inadequate prenatal care are also those who have had the most deprived background and environment, it is difficult to know to what extent the relationship between adequate care and superior health status plays a part in the relationship between inadequate care and complications of pregnancy.

It seems clear, then, that some of our most impressive correlations may need further analysis, with adequate control for socioeconomic level, before we are sure to what extent the associations reveal causes. The need for further analysis is evident in the figures presented early in this chapter, about complications of pregnancy. When married and unmarried were separated into white, nonwhite and Puerto Rican, the differences between groups were greater than the differences between married and unmarried. However, these differences—as has just been pointed out—may relate chiefly to differences in socioeconomic level.

The correlation between complications of pregnancy and deprivation is recognized, although perhaps not as widely as it should be. What has not been generally recognized is that this same correlation *may* account for a good deal of the correlation between complications of pregnancy and prenatal care—since absence of adequate care is so strongly related to deprivation.

It does not lie within the purpose or the competence of the present review to determine to what extent prenatal care, environ-

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\*Herzog, 1962.

ment during pregnancy, or early environmental influences determine the course and outcome of pregnancy. For present purposes it is enough to recognize that all these influences play a significant part. This recognition is important to our review, since it suggests once more that the medical hazards of births out of wedlock cannot be eliminated by services directed specifically to unmarried mothers. They involve broad and basic problems of public health, which can be met only by diminishing deprivation for all members of the most deprived segments of our population—deprivation that during pregnancy may exact a toll for disadvantages persisting since birth, or before.

### 3. Efforts to Extend and Coordinate Medical and Social Services

A number of reports deal with efforts to eliminate or reduce some of the major deterrents to adequate maternity care. The general objective has been both to reach more unmarried mothers and to give more comprehensive services to those who are reached. The chief methods used for achieving this end were: (a) coordination of medical and social services; (b) help with medical and living expenses during pregnancy.

#### *Social services in hospitals and clinics*

Only 15 percent of the Nation's hospitals have social service departments.\* Except for a few scattered studies, there is little systematic information about the availability and use of social services for unmarried mothers in medical settings.

Hospital policies vary with regard to the extent of social service coverage. Some aim for 100 percent coverage for unmarried mothers, at least to the extent of one contact. This is true of only a small proportion, primarily voluntary hospitals, which serve a relatively small proportion of unmarried mothers.

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\*American Hospital Association, 1962, p. 404.

One of the few studies involving social services in a hospital was conducted in one of the few hospitals having a "100 percent referral policy" with regard to unmarried mothers. The sample of 227 unmarried women included all who were referred to the Social Service Department from the Department of Obstetrics-Gynecology during 1956 and 1957. ". . . the (Social Service) Department knew all Prenatal Clinic and Ward registered unmarried women. The exceptions were the very few who may have concealed their unmarried status by designating themselves otherwise at the time of registration and those cared for on the private or semi-private services who would not have been referred" (p. 1).<sup>\*</sup> The ethnic distribution was: 31 percent white, 39 percent Negro, and 30 percent Puerto Rican.

The purpose of the study was to determine some of the characteristics of unmarried mothers served by the hospital, some of the medical findings, and the use they made of hospital social services as well as of other social agencies. Information was obtained from records of the Medical and Social Service Departments of the hospital.

Some of the medical findings have already been referred to, as has the clinic policy of giving priority to women who applied before their seventh month of pregnancy. With regard to social services, 27 percent of the women were not known to any social agency other than The Mount Sinai Hospital Social Service Department; 34 percent were known to one other agency, usually the Department of Public Welfare, 22 percent were known to two other agencies, and 17 percent to three or more. "The variations among ethnic groups were very pronounced: in the white group 1 percent was known to only The Mount Sinai Hospital Social Service Department in contrast to 36 percent for the Negro and 43 percent for the Puerto Rican women." Of the white group, 86 percent were known to two or more other social agencies. The white unmarried mothers used a social agency chiefly in relation to planning an adoption placement for the baby. The Negro and Puerto Rican unmarried mothers turned to a social agency chiefly for financial assistance in maintaining a family unit.

A separate discussion of the Mount Sinai study reported that the majority of the sample evinced no sense of need for social services, although often during a first interview the evidence of interest and available help was a revelation that might make the unmarried mother aware of possible benefits and aware also "that she is not obliged to meet her situation unassisted. And most of the group, regardless of feeling or motivation, have the very real problem of planning for the newborn."<sup>\*\*\*</sup>

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<sup>\*</sup>Rashbaum et al., 1962.

<sup>\*\*</sup>Paneth, 1961.

That the "100 percent coverage policy" of The Mount Sinai Hospital is rare in New York City is evident in the figures reported by the Community Council study, involving a sample of the city hospitals that was reasonably representative with regard to unmarried mothers, although it excluded proprietary hospitals, hospitals in which less than 50 unwed women are confined per year, and one large municipal hospital.\* In this study it was found that 88 percent of the unmarried mothers interviewed in hospital wards had gone to a clinic for medical care, but only 40 percent had contact with the clinic social worker. Moreover, about one-third of this group indicated that they did not need or want any help—that is, the unmarried mother apparently made the contact only because it was required by clinic policy or school or court regulation.

For the most part, as reported by this study, contact with the hospital social services appeared to be brief. About one-third consisted of referral to another agency, and about one-fourth involved some type of casework service. In fact, over one-third (37 percent) of all the contacts with social agencies involved chiefly referral services. (Comparable figures were not given for the Mount Sinai study.) "Most unwed mothers," remarks the Community Council report, "do not establish contact with social agencies on their own initiative or on the basis of their own knowledge about agencies" (p. 116). The unmarried mother herself initiated only about 6 percent of the contacts with some social agencies, but as many as 21 percent with the hospital social service.

A study of "Young Unmarried Mothers in Child Health Stations of Two New York City Districts" was motivated by a concern that "more intensive casework may be needed, but is often delayed or completely omitted because of long waiting lists and staff shortages which exist in community agencies to which these mothers are referred."\*\* The study was undertaken to "assess the factors which contribute toward these difficulties and to establish their significance." Further purposes were: (1) To gain a better understanding of the extent and type of the economic, social and medical problems faced by unmarried mothers whose infants receive health supervision in child health stations; (2) To compare with married mothers seen in same health stations; (3) To determine what additional health department resources, if any, are required to meet more adequately the needs of the unmarried group; (4) To determine how the education of the staff, doctors and nurses, could be improved for more effective

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\*Bernstein and Sauber, 1960.

\*\*Bleiberg et al., 1962.

service in the child health conference.

The study concentrated on "very young mothers, because it was felt that they were a very vulnerable group and would profit most from rehabilitation." Accordingly, the 300 selected for interviewing (during 1960) were all under 22 years of age.

For the most part this is a study of the overt characteristics of young unmarried mothers from a deprived area who were known to a child health conference through the care of their babies. Some psychological factors, such as attitudes toward the out-of-wedlock pregnancy, social stigma, and concern about social and emotional problems were also mentioned.

The interviewers were all physicians in the clinic, who tended to take at face value the statements of the unmarried mothers about their problems. "Comments regarding social and emotional problems were not very impressive. Only 14 percent of the unmarried mothers were reported to have serious social problems by the interviewing physicians . . . ." The authors of the report considered this finding "most likely a reflection of the limitations of professional training of doctors," commenting that "as the total environmental setting and the family constellation play a decisive role in the maintenance of the social and emotional growth of children, increased sensitivity of all medical personnel, including the doctors, to these factors must be developed and constantly nurtured."

Some of the conclusions reported, then, were based more on what the study data did not show than on analysis of those data. The study "pointed up the necessity to make social services available in child health stations of low income districts . . . ." Initially, a part-time social worker was attached to the project, and "upon periodic review of the completed questionnaires mothers requiring assistance were referred to her." The amount of available social work time was increased as the need for more professional help became evident. In the view of the investigators, the study pointed up also that "much greater effort needs to be made to alert the medical staff to the socio-economic and emotional problems of mothers, children, and their families. Although it has been stated many times that physical health is only one segment of the total health spectrum this concept has not yet taken deep roots in medical practice. There is a need to intensify and broaden the education of physicians if medicine is to come to grips with the complexities of caring for people" (p. 2039).

Apparently, then, this was one of those projects that had a substantial impact on those conducting it, and resulted in changes that grew more from its effects on the medical staff involved than from the research characteristics of the study design or its execution. As the authors put it, "the study was used as an educational device for physicians and nurses" (p. 2040).



## *Community programs*

The specific objectives of community programs for extending and coordinating prenatal services to unmarried mothers have been differently formulated and are sometimes merely implied: to bring more unmarried mothers into service; to bring more kinds of service to each unmarried mother served; to keep unmarried mothers from making independent adoption placements.

The studies and demonstrations concerned with such efforts have been directed primarily toward two groups of unmarried mothers: (1) those who are becoming known to hospitals and social agencies "too late," having waited until late in pregnancy to come into medical care, and not having had social services prior to this time; (2) those who are not coming into the purview of community medical and social agencies, and are making their own medical plans privately and conducting independent arrangements for adoptive placement. The second group tend to be primarily the "older" (over 20), white, self-maintaining unmarried mothers, who are likely to be nonresidents.

For the most part, this kind of effort has been of the sort that could be classified as a demonstration. It has usually involved a single community although some demonstrations cover a county or even a whole State. The focus has been on programs and activities, rather than on systematically recording or testing results. Accordingly (with a few outstanding exceptions), the reports reviewed tended to be much influenced by local conditions and the findings reported tended to be derived from convictions and principles rather than from evidence.

In this situation detailed discussion of each project would be unrewarding. It is possible, however, to report briefly on some of the more documented attempts and to summarize the most frequent conclusions and recommendations in the others, with some indication of the extent to which they seem to be supported by evidence.

The measures employed include efforts to achieve better communication between different agencies; better definition of areas of overlap or complementary service; better referral systems; the removal or reduction of certain deterrents believed or demonstrated to prevent unmarried mothers from availing themselves of services. The main deterrent that has been aimed at is the cost of private medical care. Several of the demonstrations included efforts to cope with this deterrent by help in covering the costs of medical care and—in some instances—helping to meet living expenses for the unmarried mother-to-be. The methods for giving such aid vary considerably, but the expressed purpose is relatively constant: to bring more unmarried mothers into service, earlier in the pregnancy than would

otherwise be the case, and to minimize any need for turning to independent adoption placements as a means of covering medical expenses. Various forms of help with medical costs have been employed, including help to permit expectant mothers to continue receiving care from their own physicians. The usual arrangement in such cases is that the payment is made directly to the doctor by the agency.

Two major programs for coordinating medical and social services, both continuing over a period of more than 10 years, were conducted, respectively, by a State Department of Health (Connecticut) and a voluntary social agency that eventually extended its services throughout the State (Seattle, Washington).

One of these, the most systematically reported of its kind among those reviewed, was begun in 1952 under the auspices of the Connecticut State Department of Health, and has periodically introduced modifications based on experience. Although the number of unmarried mothers served was relatively small in the first two years, there has been a steady increase during the years of the demonstration. The cumulative effect of the program has seemed favorable enough that it is still under way and has broadened its area of coverage beyond the three counties originally involved.\*

The program, which grew out of the administration of the Emergency Maternity and Infant Care (EMIC) program during World War II, offers medical care coordinated with social care. The medical care could be provided through private physicians, community hospitals, and maternity homes. Social care was provided primarily by voluntary agencies and the Division of Child Welfare of the State Department of Welfare. Referral could be made on the girl's behalf by the project staff, with her consent, and her eligibility was determined on the basis of information furnished by the physician or social worker. Thus, through one application, she could obtain both medical and social services.

The Connecticut demonstration produced findings, conclusions and recommendations generally in line with those reported by other smaller, less long-lived, and less systematically reported efforts. Accordingly, it will be referred to more often than others, with identification of any points that seem to diverge from the findings of others.

The other demonstration that resulted in a program extending well over 10 years has been conducted by the Children's Home Society in Seattle, Washington, and also calls for special attention. Begun as a local experiment in 1949 (after a year of advance planning), this program now serves unmarried mothers throughout the State and is

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\*Curtis and deRongé, 1957.

described as having the largest maternity care program in the State.

The purpose of the demonstration was to provide to unmarried mothers coordinated medical and casework services, help in meeting medical and living costs, help in planning on a differentiated basis, and help with adoption placement for those unmarried mothers who—with casework help—decided on this step.\*

### *Gains ascribed to coordination of services*

A major value, mentioned in virtually every report of efforts to coordinate services, concerns the improvement in group and individual inter-relations that results from contact between members of different agencies and different professions or disciplines—often coupled with reports of a consequent improvement in services. To a large extent this gain has to do with information: they learn about the functions, methods and goals of others. They are amazed at what they did not know about others and what others did not know about them. This point comes out again and again. Among the professional groups specifically mentioned by the Connecticut report as benefiting by this interchange are: social workers, physicians, hospital nurses, public health nurses, lawyers, clergymen, school officials and teachers, policewomen.

Others, too, often report that physicians learn to know more about social workers in the community and what they do, that social agency social workers and hospital nurses finally become acquainted with the great assistance offered by public health nurses, that school people learn what all the others can contribute and all the others learn how much can be accomplished through collaboration with the schools. The public health nurse receives special mention as a professional person who comes into her own when community agencies learn how much she has to offer to them and to those they serve. The Connecticut demonstration, for example, after two years of operation, added to its project staff a public health nurse who has contact with unmarried mothers who frequently do not use social services. Another example of continued interdisciplinary cooperation in this project is the increased concern with school problems by the Statewide Advisory Committee—which, itself, was established as a result of the demonstration, and which served as an ongoing body for the continued review of problems, needs and services.

A corollary to increased information, already noted, is likely to

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\*Hall, 1951, supplemented by unpublished correspondence, 1962.

be closer and more effective working relations. This, in fact, is the expressed goal of a good many projects, and is often reported as a major result.

Other reported gains have to do with bringing more unmarried mothers into service. A number of projects, including the Connecticut and Washington programs, reported that as a result of the demonstrations some unmarried mothers were receiving medical and social services earlier than would otherwise have been the case, and that some who otherwise would not have received services did receive them. The Connecticut investigators do not claim that all recent improvements are directly due to the program, but do state that it probably has been an influencing factor.\*

In the first two years of the Connecticut program 27 unmarried mothers were assisted to meet medical and, in some cases, living expenses. The investigators definitely stated that only one of these was deterred from making an unprotected adoption placement, although they believed that relief from financial worry enabled several others to place their babies "more thoughtfully." It was believed, too, that because of freedom from debt for medical care, two or three of the five mothers who kept their babies felt freer to make that decision.

There is some ambiguity, even in this most carefully reported of the projects of this type that were reviewed. However, a careful reading seems to indicate that a maximum of seven, or slightly more than 25 percent of the 27 unmarried mothers served by the project during the first two years, *may* have been brought into service as a result of project activities. It should be added that the results of an ongoing program would not necessarily be reflected in the numbers reached during its earliest years, especially when—as in this case—it was engaged in developing a method of comprehensive service.

The Children's Home Society of Seattle worked with a panel of obstetricians from the city Gynecological Society, to whom cases were referred in rotation. The panel members agreed to give all prenatal, delivery and postnatal care for a flat fee, established in advance and considerably less than the usual cost of private care. (This service was, as noted earlier, coordinated with casework services.) The fee was paid directly to the physician by the agency, if the unwed mother was not able to pay herself, and she could be served by her own physician if he would accept the agency rate. She would be delivered on private hospital service, except for those who were on public assistance, who were delivered on public services. If the girl was under 21 and eligible, the State department of public assistance paid

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\*Whether or not it has anything to do with the projects, it is interesting to note that Connecticut and Washington appear to have relatively high proportions of unmarried mothers receiving services from social agencies.

the agency part of the costs. It is said that many unmarried mothers later repay the agency for their expenses.

A number of other demonstrations and programs that offer help in covering the costs of medical care have placed stronger emphasis on the purpose of deterring unmarried mothers from placing their babies for adoption without the protection provided by social agency services.\*

In both the Connecticut and the Washington studies, as in some others, the age of the applicants suggests that programs which offer help in meeting the costs of medical care and living arrangements are likely to bring in applicants who may have seen themselves previously as not needing community agency services. They appeal to older, less "dependent" unmarried mothers—whether "dependent" be construed psychologically or economically. Requests for financial help with living arrangements reported by this kind of program are likely to come from a minority of the unmarried mothers served—23 percent, in one study. Of course, in pointing out that only a minority ask for help with living arrangements, it is not forgotten that (1) a larger proportion need help with the costs of medical care; (2) relieving them of the costs of medical care frees them to use whatever resources they may have toward living arrangements and other needs; (3) even if only a few need help with other expenses, it may be well worth helping those few; (4) a small proportion of a large number can still be numerically large.

The relatively small proportion who seemed to require financial help, in these and other similar demonstrations, brings out an interesting characteristic of the reports reviewed. Although the descriptive studies dealt chiefly with unmarried mothers of low socioeconomic status who were receiving inadequate prenatal care, the demonstrations of programs for extending medical care seemed to involve chiefly unmarried mothers who were better off economically and socially.

### *Some questions of cause and effect*

The efforts to extend services included the coordination of medical and social care, improved referral and consultation procedures, and occasional help with living expenses, as well as help with medical costs. The fullest reporting, however, was given in relation to help with the costs of medical care, although not all the unmarried mothers served received such help.

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\*For example, Heath, 1961; Nevada, 1961; Idaho, 1961, 1962.

Every demonstration reviewed, that included this feature, concluded that the availability of funds to meet medical costs and prenatal living expenses does induce some unmarried mothers to seek medical and social services, or to seek them earlier than they otherwise would; and, if the baby is to be placed in adoption, to do so through a social agency rather than under nonagency auspices. Reports were not clear, however, on the *number* and *proportion* of unmarried mothers whose course is directly affected by the provision of such resources.

One reason for uncertainty about the direct effect of help with medical costs is that demonstration projects which include it are likely to include also work with physicians and other professional people and general community interpretation at the same time. It is difficult to know to what extent an increased number of applications and referrals should be ascribed to greater interprofessional understanding and cooperation, better community understanding, or the availability of financial aid.

In the case of Connecticut, it is difficult to ascertain whether there is a direct relation between the increased use of services and the activities of the demonstration. Beginning in 1958, Connecticut law (passed in 1957) required that the placement of children in adoptive homes be handled either by a licensed child placing agency or the State Department of Public Welfare before adoption petitions could be heard. This could result in increased use of services approved by the State health and welfare authorities. Nor is it known to what extent an increase in illegitimacy or in the general population could account for the increased use of available services. And whether the number currently served is large or small would depend on the size of the potential client population—information which is not available.

With regard to the effect of covering costs of medical care and living arrangements—as on several other points—it is often not clear to what extent conclusions are based on data rather than on preconceptions. For example, in the report of a project which was set up to help meet costs of medical care throughout the State, so that the unwed expectant mother who was in need could get early care regardless of her ability to pay, the observation was made—presumably on the basis of the data—that the delays were due primarily to psychological factors. If so, then financial assistance in itself would not be a sufficient antidote; a period of help would be indicated before medical referral, directed toward relieving anxiety (with appropriate measures for protecting the girl's identity) and removing other obstacles to her acceptance of early medical care. Yet the report gave no indication that such considerations influenced the casework procedure, or that psychological obstacles prohibited medical care in spite of ability to meet its

cost, or that available money resources diminished the psychological obstacles. In other words, the gap between assessment, practice and conclusions was left unfilled.

It appears, then, that there is a strong belief in the efficacy of financial resources for bringing unmarried mothers into prenatal services, and that available evidence is not systematic enough nor relevant enough either to confirm or to contradict this belief. At the same time, there is no evidence which suggests any harm in offering such assistance. On the contrary, presumably it could be very helpful to the unmarried mothers who receive it, even if it did not speed their receipt of services and even if they would not have turned to an unprotected adoption. The fact that a measure does not demonstrably achieve a specified aim cannot be taken as evidence either that it does harm or that it fails to be helpful in other important ways.

**Recurrent conclusions.** The community programs reviewed here were aimed at extending and coordinating medical and social services for unmarried mothers. Their primary objective was to bring more unmarried mothers into service and to bring more comprehensive maternity care to those who were served. Accordingly, comments on their results are concerned primarily with availability and use of services rather than with their quality or effectiveness.

It is difficult to sum up the evidence in these reports, because for the most part they do not offer systematic, comparable, or solid evidence. Their conclusions tend to be based chiefly on the convictions that prompted the study or demonstration described in the report.\* Nevertheless, a few recurrent conclusions seem to command credence, even though they might easily have been believed without demonstration:

- **Members of the various professions concerned with serving unmarried mothers know surprisingly little about each other. Their working relations, and hence the effectiveness of their services, are improved when they increase their mutual information and understanding.**
- **If agencies and individual professional people work together, more referrals will be made and—providing they work together systematically and effectively—more clients can be served.**

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\*In this connection it is of interest that the Connecticut Department of Public Health is embarking (as of 1964) on a study of services to unmarried mothers in the State.

- If more referrals are made, more women will require care. Failure to provide in advance for this increase will mean inability to improve or expand services appreciably, and may necessitate closing or cutting down intake.
- Payment of medical costs, and in some cases of prenatal living costs, does appear to bring some unmarried mothers into prenatal care, medical and social. The evidence is clear that some of them will not accept public services and will do what is necessary to avoid them—either do without services or turn to independent arrangements. The evidence is cloudy on the *number* and *proportion* of unmarried mothers whose course is determined by the provision of payments for medical services.

## 4. Recommendations

A number of recommendations are presented in the various reports, a few are implicit in the findings reported, and one or two—neither stated nor implied—are brought home by the review itself. One of the latter is the need for making more concrete the meaning of “medical services for unmarried mothers” and especially the specific content of “prenatal care”. Ways of meeting this need can be discussed appropriately only by those who are medically competent, a description that does not apply to the present reviewers. Even the nonmedical reader, however, is impressed by the vagueness and the almost mystical aura of the term “prenatal care”. It would be interesting to know to what extent there is agreement among physicians about what it should include, how much of it is required, when it should be administered, and what different needs for it are found in different groups.

Whether consensus is reached or not, it is clear that studies attempting to relate prenatal care to outcomes of pregnancy will need to define more explicitly the meaning of the term as used in a given study, in order to obtain reliable answers to questions about the interrelation between prenatal care, health status, health history, environmental factors and outcome of pregnancy.

A very different kind of definition is required in connection with teenage unmarried mothers. “Teenage” is defined more regularly



by reports of studies and demonstrations than by those who comment on them. Commentators often refer to "the teenage unmarried mother", even though most study reports present findings by specific ages. Battaglia et al. point out that there seem to be significant differences in course and outcome of pregnancy between the early and the late teens, and these can be perceived only if they are discussed by specific age rather than being lumped in one heterogeneous group.\*

These needs for definition, obviously, hold for studies of any teenage mothers, married or unmarried. However, they have special relevance in connection with the very young unmarried mother, because of widespread discussion and concern about "the" teenage unmarried mother, and because there is good reason to have special concern about unmarried mothers who, themselves, are more children than adults.

Among the many explicit recommendations made for improving the availability and use of medical services for unmarried mothers, very few bear directly on two of the three major deterrents to early and regular prenatal care: the unmarried mother's indifference to obtaining it and her wish to conceal the pregnancy.

**Attitudes to prenatal care.** There are occasional, rather vague, references to the need for public education about the importance of obtaining adequate prenatal care, and suggestions that this information should be included in courses on family life education. However, it is sometimes added that such courses often leave much to be desired, and that some parents and school authorities object to having sex education included in special school courses or in courses on family life education. Also, some courses begin too late in the curriculum to reach those assumed to need them most. We have little or no systematic evidence concerning their effectiveness, and, on the whole, the unsystematic evidence is far from reassuring. (It is generally conceded that adequate evaluation would be difficult in the extreme.)

The fact that the college-educated unmarried mothers are the ones most likely to obtain adequate medical care suggests that better factual information about physical health and health practices would be helpful for all potential mothers, in or out of wedlock. Occasionally the point is made that if such instruction could be divorced from courses on family life education or sex education as such, and could be offered in a straight academic context, by competent teachers, it would meet less psychological resistance both from parents and from students than it apparently meets at present. There is abundant evidence that the groups in which illegitimacy is most frequent are

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\*Battaglia et al., 1963; see also Briggs et al., 1962.

grossly uninformed about the human body and about the practices required to keep it healthy, especially in an urban environment.\* This lack of information includes ignorance about the relation of general health practices and of prenatal care to prematurity and its attendant hazards. It seems likely that unmarried mothers who avoid prenatal care in the hope of a miscarriage fail to realize that they are not choosing only between keeping or losing the baby, but may also be risking a damaged baby or damage to themselves.

A wish for abortion, natural or induced, would obviously result in less effort to obtain prenatal care than would a desire to bear a healthy baby. And probably few unmarried mothers realize clearly that prenatal care involves other considerations. It is possible that if they had more factual information about the various health factors that dictate the advisability of prenatal care, their wish to lose the baby before it is born might operate less forcefully in obstructing a desire to obtain such care. This speculation is supported by the fact that the more education a woman has, the more likely is she to obtain prenatal care. It seems likely that this correlation includes a difference between the college-educated and those with less classroom knowledge of the human organism and its functions.

The advantages of transferring essential factual information from the nonacademic to the academic context were underlined at a conference sponsored by the Maternity Center Association in New York City. "There was a feeling that the courses taught in school and college under the general title *Marriage and Family Living* are often of inferior quality. Many are in the department of home economics and reach only a minority of girls who elect this course. The subject should not be elective, it was agreed, but need not be taught as a separate course. In fact, it would be better if the material were integrated into the academic subjects. . . . It was generally agreed that courses in biology offer the best opportunity to reach young people at the critical high school age. However, at the present time, there are few good text books . . . ."

The opinion here seemed to be that boys as well as girls should be taught biology and basic health practices, and also that high school students would probably be more receptive to such material when it was offered as information rather than as precept. "As one participant comments, 'Anatomy, physiology and psychology are academic

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\*According to one study, ". . . over 20% of the indigent patients did not know, prior to the onset of labor, either what the signs of labor were or when they should notify their physicians" (Kariel, 1963, p. 355).

\*\*Education for Childbearing and Parenthood, 1962, pp. 103-104.

subjects with tremendously strong implications in the actual life of the individual.' " \*

It is assumed, reasonably enough, that the kind of classroom education which would bring home—in a general health context—the need for adequate prenatal care would also eliminate ignorance about the signs of pregnancy, which is reported as one of the minor deterrents to obtaining prenatal care.

Those who recommend better instruction about the human organism and its health needs expect psychological as well as physical benefits. There is ample evidence that the majority of parents in very low income groups find it difficult to give their children sex information; and also that negative attitudes about sex and between the sexes grow stronger as one descends the socioeconomic ladder.\*\* Accordingly, children in the groups from which unmarried mothers are most likely to come are the ones most likely to receive sex information from other children rather than from adults; and to receive it in negative terms. Those who recommend classroom instruction in biology (or physiology or anatomy) as a means for increasing recognition of the importance of prenatal care usually hope that, in addition, adequate education might help to reduce the incidence of pregnancy out of wedlock.

**Concealment.** With regard to concealment, recurrent suggestions concern relaxation of some clinic policies about parental consent and identification of the putative father. Obviously, as soon as the urge to conceal is paramount, the urge to obtain prenatal care will conflict with it and will need to be very strong in order to gain ascendancy. One alternative is to have the unmarried mother assured that she can obtain care without having her condition made known to those from whom she wishes to conceal it as long as possible.

The New York Community Council study points out that unmarried mothers who are still in school feel a special need to conceal the pregnancy as long as possible, in order to avoid expulsion. School policies throughout the country differ considerably, but in many places a pregnant girl is automatically expelled as soon as the pregnancy is discovered. Accordingly she tries to conceal it, and often succeeds until the fifth month or later, thus eliminating the possibility of early referral by school authorities. In New York City and in many other places, an unmarried mother of school age can continue her schooling during a known pregnancy only if she enters a maternity home. Some cities allow pregnant schoolgirls to benefit by special

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\*Education for Childbearing and Parenthood, 1962, p. 104.

\*\*Herzog, 1963.

teachers for the physically handicapped; and a few projects now under way are experimenting with special classes for pregnant school-girls—combining medical and social services with continued academic instruction.

The reason for refusing to allow pregnant girls to attend school seems to be fear on the part of school boards and parents that the presence of a girl pregnant out of wedlock will be damaging to her classmates. A number of considerations challenge this view, and it might well be subjected to investigation. If contamination is a danger, it is likely to have had its effect before the pregnancy is discovered and the girl expelled—which is likely to happen just as the aura of romantic glamor is beginning to be succeeded by physical evidences of penalty. Most young girls want to be attractive and active. The result of a relationship leading to pregnancy is that a girl becomes heavy, unwieldy, and—for a time—less attractive than one who is not pregnant. She cannot dance or play basketball. She may be lonely and frightened and troubled. To see a classmate paying this penalty, and see visible evidence that she is about to be burdened with a responsibility which is bound to conflict with carefree fun, could have a more sobering effect on students than any number of lectures by adults who are regarded as stodgy, mealy-mouthed and alien. At the same time, the more serious of the girl's classmates may wonder how she will discharge her obligation to the baby and how it would feel to bring into the world a child to whom one could not be the kind of parent they themselves would like to have. All in all, it is conceivable that allowing pregnant girls to stay in school would discourage more illegitimacy than it would promote. One would, of course, want to consider whether remaining in the same school would be best for the girl, but her welfare appears not to be the primary basis for the rules against a pregnant girl remaining in school.

Occasional recommendations concern the part schools can play in facilitating early prenatal care for girls who become pregnant during their school years. These recommendations are related to early identification of the pregnant school-age girl through "more acute observation" by school personnel so that she may be directed to appropriate sources of help.\* They are also concerned with the practices of some schools where girls who are known to be pregnant are permanently expelled, thus encouraging continued efforts at concealment with attendant delays in seeking prenatal care, by the pregnant girl.

The two major New York City studies arrive at different conclusions regarding the activity of New York City schools in directing

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\*Bernstein and Sauber, 1960, p. 146.

pregnant students to resources for prenatal and social care, the study by the Health and Welfare Departments finding them more helpful in this regard than the Community Council study. Recommendations need to be approached, therefore, with some caution, particularly when they place the school in a position of early case-finding through observation. A recommendation for early case-finding has been made in many quarters and accepted, apparently, as desirable and effective. However, it casts the school in a role which might precipitate embarrassing situations, with possible legal complications. Some commentators urge that the school should avoid a detective function but should strive to develop the kind of relations between the students and the school nurse, counselor or social worker that would impel the students to turn to them for help. It is pointed out that such a course would require elimination of regulations making it obligatory for the nurse, counselor or social worker to tell the school authorities if they discover that a girl is pregnant.

**Problems concerning arrangements.** The third major deterrent, the difficulty of making arrangements to attend a clinic and to wait long hours for a short appointment, stimulates a considerable number of recommendations. Suggestions include changes in clinic hours to meet the needs of pregnant women, setting up clinics at more points and in more convenient places, the working out of arrangements for baby-sitting if an expectant mother already has small children. Such suggestions are often made somewhat diffidently, since the problems of understaffing and overcrowding obviously affect the ability to work out more easily manageable clinic locations, hours and appointment schedules. Nevertheless, it is generally recognized that, unless modifications can be made, many women will find or believe that it is not feasible for them to obtain prenatal care.

An implicit recommendation, relating to this and some other deterrents, is made by the California State Department of Public Health, in discussing standards for public prenatal care: "These standards and recommendations have been written with primary focus on the expectant mother and her family, rather than on those who supply the services."\* The California approach contrasts with a frequent assumption that service practices are less subject to change than the individual, and that less flexibility should be required of them. If travel time and expenses, the need to provide for the care of other children, and dissatisfactions about the clinic experience itself, are considered mainly as rationalizations of behavior determined by cultural background or by ignorance, these problems—

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\*California, Standards and Recommendations, 1960.

which can be very real and pressing—are likely to be underestimated. A program directed solely to educating these women concerning the importance of prenatal care, as if the sole obstacle were ignorance or cultural influences, is not likely to prove very effective. In assessing what will and will not work, it will be necessary to consider both the need for expectant mothers to understand the importance of prenatal care and the need for clinics and agencies to understand the realities of the pregnant woman's practical problems.

It is noteworthy that so far we have little reported evidence about the effects of tailoring prenatal medical services to the practical needs of the women for whom they are designed. There has been little effective effort to establish neighborhood clinics in convenient places, to arrange for hours that would be feasible for them, or to cut down on the long waiting for service and the frequency of need for return visits, after long waiting, in order to be seen by the physician. We do not know, therefore, to what extent the mother's perception of the need for prenatal care might be enhanced if it were less difficult for her to obtain it. Some efforts toward finding out are under way now, and reports concerning them will be awaited with interest.\*

It is interesting that the most frequent and explicit recommendations found in this review related to the deterrents reported as affecting only a minority of unmarried mothers. However, although each "minor" deterrent affected fewer than did the three major deterrents, the numbers affected by each were by no means negligible, and the numbers affected by all were very substantial indeed.

**Attitudes to medical clinics and personnel.** The unmarried mother's problems about making arrangements obviously relate to the clinic's problems of too little time, staff, space, and too many people needing to be served. These problems, in turn, relate to complaints about a forbidding climate and brusque, hurried, impersonal, apparently uninterested clinic staff; as well as to the impossibility of achieving a favorable patient-physician relationship if the appointment is brief, hurried, likely to be held with a different physician each time, and in addition there is little or no privacy. For some women, a language barrier is added to complicate and intensify the other problems. Such conditions are not likely to reduce fears of physicians and medical examinations, to foster a determination to obtain adequate prenatal care, or to encourage further visits to the clinic during this or a subsequent pregnancy.

This problem-complex, so closely bound up with manpower

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\*Gold, 1962; Bernstein, 1963.

shortage and so far-reaching in its ramifications, is often mentioned in the studies reviewed. There are occasional suggestions for changing the locations and hours of clinics, and for devising ingenious ways of helping women to meet the difficulties of baby-sitting, transportation, etc. With current shortages of staff and facilities, it may seem unrealistic to urge a strong and imaginative attack on the practical and psychological difficulties that contribute to indifference or resistance to obtaining prenatal care. Yet without such an attack the unmarried mothers who most need such care will continue to be the ones who least often receive it.

**Shortages of service and of staff.** Occasionally it is pointed out that if all the mothers—married and unmarried—who ought to seek prenatal care really did try to get it, the clinics would be so overwhelmed that they could not function at all. Now and then it is also remarked that a community should be ready to meet additional demands before launching a large-scale educational and case-finding program. This means examining the ability to meet current demands with already existing resources, and estimating realistically whether it will be possible to expand services to meet additional needs. Such comments are surprisingly rare, however.

Frequent references are made to several categories of shortage. There is need for more services of the kind we have. There is need for services different from those we have. And there is need to make more effective use of the facilities and personnel that are available.

Maternity homes represent a kind of service we do have, but in very limited supply and only under voluntary auspices. Since complications of pregnancy appear to be reduced by the shelter care offered in maternity homes, there is widespread belief that more are needed, and support seems to be building up for their establishment under public as well as private auspices, as well as for extending their services to a wider range of expectant mothers—especially in the lower income brackets.

Most reports made some reference to limitations of services and of manpower, with the implicit recommendation that resources be increased although seldom with suggestions about how to do it. For example, none of the studies and demonstrations reviewed made recommendations about increasing the personnel resources or spreading the efforts of those already available. Yet none challenged the widespread evidence that the present supply is unequal to the present demand for prenatal care, according to current standards in this country; and none challenged the widespread evidence that the demand falls far short of the need for prenatal care.

An increase in the number of physicians on the scale required to meet that need is unlikely to occur in the near future. Any ap-

proach to a solution, therefore, apparently must involve more effective use of available physicians. All the studies and demonstrations reviewed have assumed that all prenatal medical care must be given by a physician, preferably an obstetrician. This view is not universally accepted, however. In a number of developed countries with lower infant mortality rates than ours, trained nurse-midwives give most of the maternity care. Some modifications of the traditional method of giving maternity care are being tried out in this country, based on the theory that not all pregnant women need to be seen every month or oftener by a physician.\* According to some, if a woman has been thoroughly examined early in pregnancy by an obstetrician, and found to be pursuing a normal course, she can be checked adequately thereafter by other suitable members of a health team—with a physician available for immediate consultation or referral.

In such an arrangement the clinic team, made up usually of a physician, nurses, public health nurses, medical social workers, and nutritionists, would administer prenatal care, and repeated regular contact with the obstetrician would be reserved for situations which require his specialized skill and knowledge. It is pointed out that this kind of team arrangement would make possible a patient-practitioner relationship that gives support to the patient and gives to the practitioner a basis for full and detailed examination and diagnosis.

A member of the clinic team more often recommended than met with in this country is the nurse-midwife. In 1962 it was reported that there were about 500 American-trained nurse-midwives and about 15,000 midwives in England and Wales. The frequent recommendation that more nurse-midwives should be trained and employed is met by heated opposition from many members of the medical professions, while some members are equally strong in their advocacy. It was an eminent obstetrician who declared, "In over a thousand cases in which (nurse-midwives) have given complete maternity care to mothers under my general supervision, I know of only one instance in which they overlooked a major complication and so failed to report it to the physicians. As for the attitude of patients toward them, mothers who have had the care of a nurse-midwife and subsequently come back to us for another pregnancy, invariably insist on a nurse-midwife." This same physician suggested that perhaps a change of name would help to reduce the opposition to expanding our resources for obstetrical care by training more nurse-midwives.\*\*

The "clinic team" envisaged in this kind of proposal is set up

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\*Gold, 1962.

\*\*Eastman, 1962, pp. 60, 64, 66.



with recognition that the expectant mother's needs are not exclusively physical. Psychological and social elements are implied in the emphasis on the need for continuity of prenatal care. They are recognized also by including in the team sources of counseling on individual and family psychological problems.\* It is generally recommended that such teams should include members representing the fields of medicine, nursing, social work, and nutrition; and should have access to consultation from other disciplines as needed.

Although the studies and demonstrations reviewed did not deal with recommendations for clinic teams, they should be mentioned since they are now being discussed and tried out. They are the more pertinent since, on the one hand, they hold promise of more adequate prenatal care for those mothers who seek it and, on the other hand, if all mothers—married or unmarried—were to seek the approved amounts of prenatal care, there would not be enough services to accommodate them. Unless ways are found to increase resources, either by training more physicians or by “extending the arm of the physician through paramedical personnel,”\*\* success in persuading mothers to seek early and regular prenatal medical care would be disastrous.

**Eligibility.** It has been remarked earlier in the chapter that problems relating to eligibility for free medical care differ in different localities, as do the policies determining eligibility. Recommendations for dealing with these problems relate to the policies themselves and also to ways of administering them. Suggestions are made that residence requirements be relaxed, and also that insistence on obtaining parental consent for serving minors, and on identifying the putative father, be less rigid. In some localities there is strong feeling that the means test should be abolished in relation to prenatal care, and that its existence contributes to unnecessarily high rates of infant mortality.

Another group of suggestions relates to the clarity with which eligibility requirements are understood, both by the public and by the people who administer policies.

The California State Department of Public Health followed through on its statewide survey by further investigation, and in 1960 published *Standards and Recommendations for Public Prenatal Care*, in which greater clarity about policies and procedures was a leading recommendation, and minimum standards of prenatal care were spelled out. It is expressly stipulated that, in each community, policies concerning eligibility and priorities of need “should be written,

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\*Stitt et al., 1959; Stitt et al., 1960.

\*\*Hellman, 1962, p. 56.

should be available to the public, and should reflect the combined judgment of major community agencies and groups concerned with maternal health" (p. 6). According to Monahan and Spencer, energetic study continues and the Bureau of Maternal and Child Health, as of 1962, was planning a follow-up statewide survey "to determine what, if any, changes there have been in the quality, quantity, or availability of prenatal care since its 1954-56 study, and to determine the impact on prenatal care as a result of its publication of standards" (p. 119). In this State and others, various investigations are under way, and in a few active follow-up efforts have been begun. Nevertheless, the timely and broadly applicable recommendation for greater clarity about policies and procedures is more often made than followed.

Less has been said about ways of increasing public information concerning eligibility policies. The New York Community Council reported that ignorance about the availability of medical care was not a substantial deterrent to obtaining it. On the other hand, the California studies found it a more important obstacle to obtaining care. Reports differ also about the extent to which minors refrain from seeking care because they believe their parents would have to be involved—even though in some localities this may not be so.

**Cost of medical care.** A number of demonstrations and recommendations are aimed at covering the cost of medical care for unmarried mothers, sometimes to help them obtain adequate care and sometimes to combat independent adoptions. Typically, this kind of effort is stimulated by the wish to bring more unmarried mothers into social agency services.

At this point it should be noted merely that the evidence suggests more interest, on the part of unmarried mothers, in obtaining private medical care than in pecuniary gain. Apparently, some would rather dispense with prenatal medical care if they cannot obtain it from a private physician. How many are decisively influenced by this factor remains a question.

**Inadequate referral.** A recurrent recommendation is that physicians should regularly refer unmarried mothers to agencies where they will receive both medical and social services. This recommendation is the more appropriate since, according to the study of the New York Community Council, unmarried mothers are likely to visit a private physician once in order to confirm the pregnancy, and then to break off contact with him. It is also suggested that social agencies and schools be more active in making referrals for medical care and in following through on them. The study made by the New York Community Council comments especially on the very small number

of expectant mothers referred by the Bureau of Public Assistance, and suggests that the social investigators should tell unwed mothers the specific clinic which will serve them for general and prenatal medical care, and assist in making arrangements and follow through to be sure care is obtained. The report points out that this would probably entail agreements among municipal and voluntary hospitals to share the increased volume of work that would be apt to result, in order to avoid excessive overcrowding in some clinics.

**Social services in medical settings.** Social services in medical settings offer opportunities for reaching unmarried mothers who may not be accessible through social agencies. Sooner or later the majority of them become known to a prenatal clinic or obstetrical ward, especially in public hospitals in large metropolitan areas. Some of the mothers who keep their babies may become known through child health conferences. Medical social service contact in the health settings and hospitals can serve as a point of access to assistance with some of the less tangible problems which, to many of the women in the studies reviewed, did not appear as appropriate for help from a social agency.

A few points, already noted, carry implicit recommendations: only 15 percent of the Nation's hospitals have social service departments; many public hospitals discharge their maternity patients 24 to 48 hours after delivery; except in a few hospitals, serving a small proportion of unmarried mothers, referral to the social service department is not made regularly by clinic and hospital physicians and related professional personnel, and when made is not regularly followed through; and if effective referrals were made, the respective social service departments would be unable to cope with them. It seems clear that, if social services in medical settings are to be more effective, there must be more of them, their staffs must be larger, and referrals from the medical to the social service departments must be more frequent and more effectively followed through.

**Quality of medical care.** Only one study that reported specifically on unmarried mothers gave direct attention to the quality of prenatal medical care. This was the study made in New York City by the Departments of Health and Welfare. Its recommendations were implicit rather than explicit, and were conveyed by describing the differences between private and free care. The California State-wide survey did not report separately concerning services for unmarried mothers, but did lead to recommendations which would affect both the married and the unmarried. The recommendations included: performance of standard procedures for all pregnant women; written manuals available to all staff, stating the minimum standards for pre-

natal care; and adequate instruction for expectant mothers and their families about what the patient and her relatives had to do to insure adequate prenatal care.

The conditions described by these two reports, and recommendations for improvement, are discussed in the current literature\* although not in other available reports of studies and demonstrations.\*

**Postpartum care.** Available studies of medical services designed specifically for unmarried mothers have been concerned chiefly with prenatal care. No systematic studies have been found of follow-up medical care, although occasional references report the number who returned and deplore the infrequency of systematic postpartum examinations and services. A recommendation implicit in these findings is that more attention be given to the needs of unmarried mothers after they have been delivered, whether the mother keeps the baby or not. Obviously, the unmarried mother is not alone in needing postpartum attention.

More explicit recommendations concern the need to integrate medical and nursing with social services, after as well as before delivery, a point discussed below.

**Coordination of services.** Increasing recognition is given to a conception of integrated maternity care, directed to an unmarried mother's total situation and "including medical, social, psychological, and cultural aspects . . . in relation to her normal as well as her special needs," a process bound to include also her economic needs.\*\* Integrated services are found already in some medical settings, although not often enough and in many instances not developed to their full potential. The health teams discussed above represent an effort to come closer to this goal as well as to use more effectively the manpower available.

Efforts to coordinate medical and social services in the community are represented by a number of programs, including those of Connecticut and Washington State. The reports of such programs represent presumptive evidence rather than "hard proof" of the value of such programs. To obtain hard proof might be impossible and in any case would require very costly and elaborate research apparatus. If the conviction of those closely involved in these programs and the continued support of the community over more than ten years are accepted as presumptive evidence, then their value seems to be estab-

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\*See, for example, Lesser, 1963; Thompson, 1961; Stitt et al., 1964.

\*\*Bernstein, 1963, p. 54.

lished. They offer the opportunity for an unwed mother to obtain comprehensive maternity care through a single application. This means less time spent on multiple intake activities and multiple referrals, with less likelihood of dropping out along the way.

Programs of comprehensive maternity care often offer help in meeting the costs of medical care and, sometimes, help with living expenses during pregnancy. Evidence is not clear about how many come into care *because* such help is available, or how many are thereby deterred from independent adoptions. There is ample evidence, however, that prenatal care is important for the welfare of both mother and child. Therefore, if a community wants citizens to have needed services and wants to maximize the chances that the newborn will develop their best potentials as human beings and as citizens, help with prenatal expenses seems to make sense.

It has been noted that those who most need comprehensive maternity care are not necessarily the ones most often reached by the programs that have been reviewed. It may be hoped that, as the values of coordinated medical and social services become more clearly established, this kind of care will become increasingly accessible to nonwhite as well as to white unmarried mothers, and to those whose social and economic status is on the lower levels.

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